PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

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The Nativity Group—Workshop of Antonio Rossellino
—Courtesy of The Metropolitan Museum of Art

Christmas 1950

ON THIS Christmas Day of 1950, a year which we all will remember, we pause to touch hands with our members and send that ever personal greeting. Merry Christmas, Happy New Year.

In May we of the National Organization for Public Health Nursing made what we thought was the most important decision since our beginning in 1912—the vote for a two organization plan. In this we acted as one of the six national nursing organizations, all of whom are planning together for the future of professional nursing. In June our nation as a member of the United Nations voted to defend liberty in Korea and throughout the world. Our planning for structural reorganization must now be carried on simultaneously with planning for nursing in the national security program.

In war as in peace the contribution of nursing to the welfare of our people is vital. Already plans are under way for the sharing of nursepower among the military and civilian population and for caring for target area emergencies. The United States Department of Labor has placed nursing on the list of critical occupations. This means that the military must use nurses at the highest level of their skill. The Steering Committee of the Joint Board of the Six National Nursing

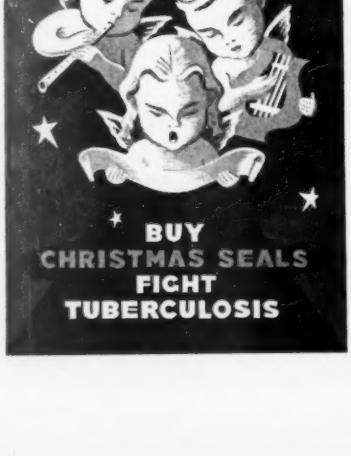
Organizations is now also acting as the Joint Committee on Nursing in the National Security. This committee will make recommendations to the National Security Resources Board which is concerned with the apportionment of the medical, dental, and nursing personnel.

This all seems a far cry from Merry Christmas. But the thinking man must realize that for some time to come, regardless of the outcome in Korea, programs for military and civil defense will be a part of the ordinary way of life. Such programs are our only hope for peace. We can take hope in the growing crusade for freedom; we can take hope in the increasing strength of the United Nations. Only yesterday freedom chimes rang out in Germany. We *must* believe that soon these chimes will be heard across the broad lands and seas and there will be, for many long and fruitful years, Peace on Earth, Good Will to Men.

EMILIE G. SARGENT, R.N.
President, NOPHN

The Fight Against TB

THIS YEAR, as never before, it is important that we double our efforts to eradicate tuberculosis. We are spending countless millions of dollars and risking thousands of lives in our efforts to stamp out totalitarianism in the world without, yet the totalitarian enemy within, tuberculosis, takes more lives each year in our own country and costs more in terms of actual money. It kills at the rate of one person every thirteen minutes—and kills at any age, from infancy to old age. Approximately 1,000,000 working years are lost annually due to time lost by those who die of tuberculosis. Each year more than $350,000,000 is expended by private and public health agencies for the care of patients and for the many other services required by the tuberculous and their families.



The National Tuberculosis Association and the local and state associations are the spearhead in the attack against this dread enemy, fighting it on four broad fronts: education, case-finding, rehabilitation, and medical research. The NTA has fought the good fight since it was organized in 1904 and has gained many notable victories. However, the NTA and its affiliates need all the help they can get. As public health nurses we owe it to our country and to the larger world to help conquer tuberculosis as quickly as possible by contributing, each one of us, our small share through the purchase of Christmas Seals.

A Shepherd

HEYWOOD BROUN

THE HOST of heaven and the angel of the Lord had filled the sky with radiance. Now the glory of God was gone and the shepherds and the sheep stood under dim starlight. The men were shaken by the wonders they had seen and heard and, like the animals, they huddled close.

"Let us now," said the eldest of the shepherds, "go even unto Bethlehem, and see this thing which has come to pass, which the Lord hath made known unto us."

The City of David lay beyond a far, high hill, upon the crest of which there danced a star. The men made haste to be away, but as they broke out of the circle there was one called Amos who remained. He dug his crook into the turf and clung to it.

"Come," cried the eldest of the shepherds, but Amos shook his head. They marveled, and one called out, "It is true. It was an angel. You heard the tidings. A Savior is born!"

"I heard," said Amos. "I will abide."

The eldest walked back from the road to the little knoll on which Amos stood.

"You do not understand," the old man told him. "We have a sign from God. An angel commanded us. We go to worship the Savior, who is even now born in Bethlehem. God has made His will manifest."

"It is not in my heart," replied Amos.

And now the eldest of the shepherds was angry.

"With your own eyes," he cried out, "you have seen the host of heaven in these dark hills. And you heard, for it was like the thunder when 'Glory to God in the highest' came ringing to us out of the night."

And again Amos said, "It is not in my heart."

Another shepherd then broke in. "Because the hills still stand and the sky has not fallen, it is not enough for Amos. He must have something louder than the voice of God."

Amos held more tightly to his crook and answered, "I have need of a whisper."

They laughed at him and said, "What should this voice say in your ear?"

He was silent and they pressed about him and shouted mockingly, "Tell us now. What says the God of Amos, the little shepherd of a hundred sheep?"

Meekness fell away from him. He took his hands from off the crook and raised them high.

"I too am a god," said Amos in a loud, strange voice, "and to my hundred sheep I am a savior."

And when the din of the angry shepherds about him slackened, Amos pointed to his hundred.

"See my flock," he said. "See the fright of them. The fear of the bright angel and of the voices is still upon them. God is busy in Bethlehem. He has no time for a hundred sheep. They are my sheep. I will abide."

This the others did not take so much amiss, for they saw that there was a terror in all the flocks and they too knew the ways of sheep. And before the shepherds departed on the road to Bethlehem toward the bright star, each talked to Amos and told him what he should do for the care of the several flocks. And yet one or two turned back a moment to taunt Amos, before they reached the dip in the road which led to the City of David. It was said, "We shall see new glories at the throne of God, and you, Amos, you will see sheep."

Amos paid no heed, for he thought to himself, "One shepherd the less will not matter at the throne of God." Nor did he have time to be troubled that he was not to see the Child who was come to save the world. There was much to be done among the flocks and Amos walked between the sheep and made under his tongue a clucking noise, which was a way he had, and to his hundred and to the others it was a sound more fine and friendly than the voice of the bright angel. Presently the animals ceased to tremble and they began to graze as the sun came up over the hill where the star had been.

"For sheep," said Amos to himself, "the angels shine too much. A shepherd is better."

With the morning the others came up the road from Bethlehem, and they told Amos of the manger and of the wise men who had mingled there with the shepherds. And they described to him the gifts: gold, frankincense and myrrh. And when they were done they said, "And did you see wonders here in the fields with the sheep?"

Amos told them, "Now my hundred are one hundred and one," and he showed them a lamb which had been born just before the dawn.

"Was there for this a great voice out of heaven?" asked the eldest of the shepherds.

Amos shook his head and smiled, and there was upon his face that which seemed to the shepherds a wonder even in a night of wonders.

"To my heart," he said, "there came a whisper."

New Social Security for Nurses

WILBUR J. COHEN

GROWING AWARENESS of the vital role of the professional nurse in today's complex social structure is adding year by year to the standing of the public health nurse throughout medical and related fields. Certainly, this public recognition of the importance of the nursing profession is well deserved. More than that, it is perhaps a natural outgrowth of our increasing attention to high standards of public health and to public welfare in general.

It seems almost paradoxical that members of a profession contributing so much to healthful and secure living should themselves have been left outside the scope of the broad federal insurance program aimed at preventing insecurity. Failure to include most nurses in the federal retirement and survivors insurance program when the Social Security Act became effective more than a decade ago was largely unintentional. Their omission was not the result of an effort to set the professional nurse apart from other occupations which were afforded coverage under the federal social insurance program at the outset. It happened, rather, that nurses are associated with one or another of several broad areas of employment which then were considered too difficult to cover under the program.

Private nonprofit organizations, including many hospitals, voluntary agencies, and religious or charitable institutions, were traditionally a group exempt from income taxes and it was felt by some that this status would be endangered if they became subject to the payroll tax which supports federal old-age and survivors insurance benefits. An obstacle to coverage of employees of states, counties, and municipalities appeared in the constitutional difficulties involved in imposing a federal levy on the state or local government in its capacity of employer. The self-employed nurse also found herself excluded because coverage of self-employed persons seemed to involve various administrative difficulties in a new program. The result was that relatively few nurses (those employed by physicians or other private individuals or firms or by hospitals or clinics organized for profit) were covered by the federal social insurance system.

Broader Coverage for Nurses

Solutions to all of these problems have since been worked out, and many additional members of the nursing profession will soon have the opportunity to acquire federal old-age and survivors insurance coverage under recent changes in the Social Security Act. Specific provisions for extending coverage under the new legislation are different with respect to each of the three broad classes of employment with which many nurses are associated.

The nurse employed by a voluntary agency, nonprofit hospital, or other nonprofit institution can become covered by January 1, 1951,

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or thereafter, if the employing organization and at least two thirds of the employees want coverage. Employees who do not desire coverage will not be brought under federal old-age and survivors insurance even though the remaining two thirds, or more, become covered. New employees coming into an organization which had decided in favor of coverage would be covered on a compulsory basis. So would former employees who were rehired by such an organization.

Certain employees cannot be covered in any case. These include student nurses and members of religious orders performing duties required by the order. Service by any employee would not be covered if the pay is less than $50 for a calendar quarter.

A nurse employed by a state, county, city, or other local government could be covered under a somewhat different arrangement provided for such employees. The state, if it so desired, would negotiate an agreement with the federal government for coverage of the group of employees in which the nurse would be classed. With certain important exceptions, this group would consist of all employees of the city, the county, or the state. Employees in positions covered by a government retirement system could not be covered under a federal-state agreement.

The self-employed nurse becomes covered automatically under the new legislation, starting January 1, 1951, if she clears at least $400 from self-employment in a year. The self-employed nurse will report her self-employment income once a year, and pay her social security contribution when she files her income tax return.

How OASI Works

Those nurses who have been covered by federal old-age and survivors insurance in the past or have seen it at work in alleviating financial difficulty among old people or in fatherless homes, understand in general how this program operates. Its objective is to provide a partial replacement of the income lost by a worker upon retirement or by a family when the breadwinner dies. The new legislation, by broadening coverage and increasing benefits and making it easier to qualify for benefits, assures the accomplishment of these objectives in far greater measure.

Briefly, here is what the program provides for persons who are newly covered. Monthly retirement benefits are payable at or after age 65 to the "insured" worker who is no longer regularly engaged in covered employment. Monthly benefits are also paid to certain dependents of the retired individual. These include unmarried children under age 18, a wife or a dependent husband who has reached age 65, or a wife at any age with a child under age 18 who is eligible for benefits.

TABLE I. BENEFIT AMOUNTS PAYABLE AT GIVEN LEVELS OF AVERAGE MONTHLY EARNINGS UNDER THE NEW BENEFIT FORMULA

Average Monthly Earnings	Retired Worker Alone	Retired Worker and Wife (or Dependent Husband)
$ 50	$25.00	$ 37.50
100	50.00	75.00
150	57.50	86.30
200	65.00	97.50
250	72.50	108.80
300	80.00	120.00

Retirement benefit amounts payable to those newly covered under the old-age and survivors insurance program will be based on the worker's average earnings in covered employment starting January 1, 1951. A new benefit formula, available to persons retiring about the middle of 1952 and thereafter, provides a monthly benefit amount equal to 50 percent of the first $100 of a worker's average monthly earnings in covered employment, plus 15 percent of the earnings between $100 and $300 a month. The benefit amounts payable under the new formula at given levels of average monthly earnings are shown in Table I. A worker can become eligible for retirement benefits by earning at least one quarter of coverage for each two calendar quarters between January 1, 1951, and the time he or she becomes 65. (A quarter of coverage is a calendar quarter in which an employee is paid at least $50 for covered work or is credited with self-

employment income of at least $100.) At least six quarters of coverage are needed. Quarters of coverage may be earned before or after age 65. Those earned before 1951 by persons who have had previous covered employment would also count.

Payment of benefits does not depend on findings of individual need, and there is no investigation into the individual's income and circumstances. However, since the benefits are *retirement* benefits, a beneficiary aged 65 to 74 is not eligible for a benefit check for any month in which the beneficiary's earnings in covered employment are more than $50. There are comparable restrictions on the payment of benefit checks to beneficiaries who do substantial work in self-employment and whose earnings from self-employment exceed $600 in a year. After the beneficiary reaches age 75, benefits are payable regardless of the amount of the beneficiary's earnings.

Survivors Benefits

Survivors insurance benefits are payable under the following conditions. If the deceased worker had as much as a year and a half of covered employment during the three years before his death, monthly benefits would be payable to children under age 18 who were dependent on the deceased worker, and to their mother. If the deceased worker was in covered employment at least half of the time between January 1, 1951, and his death, or for ten years, then the monthly benefits would be payable to children under age 18 and their mother, to a widow or dependent widower at age 65, or to dependent parents after they reach age 65.

Benefits to a surviving family will range from $15 up to a maximum of $150 a month. A lump-sum death payment will be made—whether or not monthly benefits are payable—in every instance where the deceased worker had met employment requirements for any type of monthly benefits.

Several new types of benefits provided by the recent legislation represent valuable added protection for women workers. The new provisions will permit payments in many instances to the surviving child or children of an employed mother. For example, where the deceased mother was in covered employment for the required length of time and averaged $200 a month, a surviving child would receive a monthly benefit of $48.80 up to age 18. If she was survived by two children under age 18, their benefits would total $81.30 a month. In either instance an initial lump-sum death payment of $195 would also be made. Other benefits provided by the legislation are those payable under certain conditions to the dependent husband or widower of a woman who was regularly employed in covered work.

Cost of Benefits

Financing of federal old-age and survivors insurance is based on a payroll tax on covered employment. The tax schedule provided under the new legislation is shown in Table II. The schedule applies to the first $3,600 of yearly salary or wages paid to a covered employee. That part of the annual earnings in excess of $3,600 from one employer is not subject to the tax and is not creditable toward social security benefits.

TABLE II. TAX SCHEDULE PROVIDED UNDER RECENT CHANGES IN THE SOCIAL SECURITY ACT

Calendar Year	Employee (percent)	Employer (percent)
1951-53	1½	1½
1954-59	2	2
1960-64	2½	2½
1965-69	3	3
1970 and after	3¼	3¼

The rate for a self-employed person is three fourths of the combined rates given above for employees and employers. A self-employed nurse will not be required to pay the social security tax on any part of her total earnings (including self-employment and salary) in excess of $3,600. Both types of income up to a combined total of $3,600 would be credited towards social security benefits.

Earnings of employees who become covered by old-age and survivors insurance will be reported quarterly by the employing organ-

(Continued on page 648)

Children Get Cancer Too!

. . . and nurse, teacher, and parent must be eternally vigilant for the warning symptoms.

GENEVIEVE R. SOLLER, R.N.
MARGARET F. KNAPP, R.N.
ROSALIE I. PETERSON, R.N.

HOW GRAVE IS the cancer problem among children? In 1947 it claimed more lives in the age group 1 to 14 than tuberculosis and heart disease combined, according to the National Office of Vital Statistics. Although traditionally believed a disease of middle life or old age, cancer ranked third among the first twelve causes of death in that year. (See Table I.) Of 33,344 deaths, 7.5 percent were due to cancer including leukemia, more than three times the figure for diphtheria.

The popular belief that cancer is seldom encountered in children is strengthened by newspaper reports playing up the supposedly rare case, which always ends fatally. Nurses themselves may not be fully aware of the extent of child cancer because so few cases appear in the hospital, clinic, or family caseload.

The actual incidence of cancer of all sites in children under 10 years is shown by Dorn's morbidity studies.[1] The rate is 8 per 100,000 for boys and 6 per 100,000 for girls. Table II from the National Office of Vital Statistics shows that:

1. In 1947 there were more deaths from malignant neoplasms among children 1 to 4, the preschool period, than in the early school period, 5 to 9, or the later school period, 10 to 14.

2. More than half the deaths in the age group 1 to 4 years were due to leukemia.

3. Deaths declined consistently for the three age groups.

These data should make the nurse conscious of several specific needs. First, to supplant incorrect beliefs with truths. Cancer can and does occur in any age group. Malignant tumors are a real threat to life of the preschool and school age child. Second, to understand why cancer ranks high as a cause of death in childhood. It is probably because deaths from infectious diseases of childhood have declined as a result of preventive and therapeutic measures. Also, cancer is being suspected, diagnosed, and reported more accurately. Third, to direct greater effort toward casefinding in the age group 1 to 14 to save lives.

A variety of benign and malignant tumors may occur in childhood, but the stimulus which causes these new and abnormal growths is not known. Heredity has been mentioned as a factor but there is little, if any, evidence to support this theory. One exception, of course, is retinoblastoma (glioma of the ret-

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TABLE I
LEADING CAUSES OF DEATH FOR CHILDREN AGED 1 THROUGH 14, UNITED STATES, 1947*

Cause of Death	Number	Percent of All Causes
All causes	33,344	100.0
1. Accidental deaths	10,731	32.2
2. Pneumonia	3,240	9.7
3. Cancer, including leukemias	2,490	7.5
4. Tuberculosis	1,328	4.0
5. Heart disease	1,131	3.4
6. Congenital malformation of cardiovascular system	920	2.8
7. Meningitis	823	2.5
8. Congenital malformation of nervous system	810	2.4
9. Diarrhea, enteritis	724	2.2
10. Appendicitis	700	2.1
11. Nephritis	668	2.0
12. Diphtheria	637	1.9

ina) which is known to be familial. It is important to find the tumor early for, whether benign or malignant, it may be incompatible with life and result in death.

Cancer in childhood differs in many respects from cancer in the adult. In the child the course of the disease is shorter since the tumor tends to grow very rapidly, metastasize early, and account for a large number of deaths. In general, the illness period is quite brief due to intercurrent infection or metastasis to vital areas. The lungs, bones, lymph nodes, and brain are the most common metastatic sites. In childhood the primary tumors most often originate in the central nervous system, the eye and orbit, the kidney region, the bones, and the hematopoietic system (leukemia, lymphoma, Hodgkin's disease). In the adult, on the other hand, the common primary seats are the gastrointestinal tract, breast, uterus, prostate, lip, and lung.

Most authors state that cancer in childhood tends to follow a definite age and organ pattern. It would be helpful for the nurse to remember that between the ages of 1 and 3 years teratoma, embryoma of the kidney (Wilms' tumor), retinoblastoma (glioma), and neuroblastoma are most frequent. Between the ages of 4 to 12 years tumors of the central nervous system, leukemia, lymphoma and Hodgkin's disease, and endothelial myeloma of the bone (Ewing's tumor) are most common.

Symptoms

There are no significant early symptoms of cancer in childhood. Frequently the onset resembles an acute respiratory infection which is misleading and often causes the parent to delay seeking medical attention. The single, and most often the only, indication of a malignant tumor is an unexplained mass. Naturally, as the mass grows it tends to create pressure and to interfere with the function of the diseased tissue or body part. Unfortunately, pain, one of the strongest motivating forces, is usually lacking until the tumor is apparent and advanced.

Since there are no clear-cut clinical symptoms it would seem prudent for parents, teachers, and nurses to develop an awareness of signs and symptoms which should have medical evaluation. They are:

1. Silent swelling, mass, or "lump." Any abnormal, persistent swelling of the neck, orbit, abdomen, pelvis, breast, arm, flank, or leg should be significant.
2. Pressure symptoms such as headaches, nausea, and vomiting not associated with food consumption.
3. Visual changes indicated by stumbling or turning the head so that the unaffected eye may be used for vision.
4. Functional disturbances, such as unsteady gait, vertigo, or impaired function of leg or arm associated with pain.
5. Mental changes observable in disposition, physical and mental accomplishment, and social adjustment.
6. Illness that does not run a normal course.

Diagnosis

The diagnosis of cancer in childhood can be very difficult because the clinical symptoms are often indefinite or masked. The physician must rely upon a careful history, physical examination, and the use of diag-

* U. S. Public Health Service, National Office of Vital Statistics. *Vital statistics of the United States, 1947.* Washington, D.C., U. S. Government Printing Office, 1949.

TABLE II. DEATHS FROM CANCER, INCLUDING LEUKEMIAS, AMONG CHILDREN 1 THROUGH 14, UNITED STATES, 1947*

Age	Total Neoplasms		Cancer (List Nos. 45-55)		Leukemias (List No. 74)	
	Number	Percent	Number	Percent	Number	Percent
Total (1-14)	2,490	100.0	1,305	52.4	1,185	47.6
1-4	1,173	100.0	572	48.8	601	51.2
5-9	755	100.0	398	52.7	357	47.3
10-14	562	100.0	335	59.6	227	40.4

nostic tests. In children as in adults the biopsy with histologic examination provides the most accurate diagnosis. Roentgenologic technics are generally employed in suspected bone tumors and intracranial, intrathoracic, and renal cancers. It is regrettable and handicapping, but there is no single test, such as the serologic test for syphilis, that can be used to find cancer. Blood studies are helpful in diagnosing the lymphoid group. Blood calcium, phosphorus, and phosphatase tests, in conjunction with roentgenography, are used for diagnostic as well as prognostic values in bone cancer. It becomes apparent, then, that every physician who examines children has a great and challenging responsibility in early recognition of cancer so that the full potential of therapy can be realized.

Treatment

Dargeon[2] claims that "clinically recognized cancer is not early cancer. The young patient who presents himself with a neoplasm has already lost much time and a rapid and aggressive approach to his problem is required." The treatment used in most instances is surgery, irradiation, or a combination of the two. Research is going on in the use of antibiotics and chemotherapeutic agents but there is no conclusive evidence supporting their value.

As gloomy as the situation may seem "cures" are possible. Dargeon[3] states:

> An increasing number of survivals for five and ten years after treatment are being reported. Although certain tumors (medullo blastomas and lymphomas, for example) have a consistently high unfavorable prognosis, there is encouragement in reliable reports of long periods of survival among children who have had many of the other varieties of cancer: intracranial tumors, osteogenic sarcoma, retinoblastoma, and sarcomas of soft somatic structure, that is, fat, nerve, and muscle.

Farber[4] sets forth a valuable rule for the physician which may well serve as a guide to the nurse: "Every solid mass in an infant or child should be regarded as a malignant tumor until its exact nature is determined by histologic examination of the removed tumor."

Tumors

At this point it might be well to discuss briefly some of the more common types of cancer in childhood.

1. *Retinoblastoma* (glioma retinae) is a well known variety, hereditary in nature, that usually occurs before the fifth year of life. This tumor may be unilateral or bilateral. Dargeon[5] reports that in a series of 48 cases the average age was found to be 14 months and more than 50 percent were bilateral. The cardinal clinical symptoms are: bulging eyeball, strabismus, dilatation, and peculiar greyish-white appearance of the pupil. It is most often the mother who notices that the child has visual symptoms, such as squinting, turning or tilting the head to see, or stumbling into furniture.

The treatment of this tumor depends upon whether it is unilateral or bilateral. If unilateral, an enucleation is done; the other eye is watched carefully and examined at frequent intervals because of the great possibility of spread. The appearance of the tumor in the other eye may be almost immediate or months later. If bilateral, an enucleation is generally done of the more involved eye, and fractionated irradiation given the re-

* *Ibid.*

maining eye. Sometimes bilateral enucleation is employed. The prognosis in retinoblastoma is poor. In any eventuality, parents are confronted with the problem of having a child with a loss of vision in the one eye, total blindness, or death. Since retinoblastoma is familial it might be well to include information regarding this condition in marriage counseling, when necessary.

2. *Brain tumors* are not uncommon. However, they are relatively more frequent in children than adults. The symptoms may be headache, dizziness, or explosive recurrent vomiting without relation to taking food. There may be an observable widening of cranial sutures, simulating a true hydrocephalus. Older children may have a change in personality, become inattentive or disobedient, or complain of vague symptoms. The treatment is usually surgical removal. There are reports of many tumors removed before permanent damage took place.

In the experience of one of the writers, who served as public health nurse in a school system, such a case was observed. An alert fourth grade teacher referred a nine-year-old boy for an eye examination because he complained that he could not see the blackboard. The cumulative health record revealed nothing, but his complaint of progressively worse headaches prompted referral to an ophthalmologist. The examination disclosed the presence of a tumor which was subsequently removed by surgery.

3. *Neuroblastoma* is one of the more common cancers of childhood. It is one of a series arising from the sympathetic nervous system either in the adrenal medulla or in similar tissue adjacent to the adrenal or elsewhere in the body. A mass in the abdomen is often the most important indication of this tumor. There may be complaint of pain in the back or extremities as a result of metastasis which occurs very early. Other symptoms may be fever, anorexia, diarrhea, or constipation. This tumor is radio-sensitive. The treatment of choice seems to be surgical removal of the tumor followed by irradiation therapy, when possible. Until recently the literature regarded this tumor as almost completely untreatable.

4. *Kidney tumor* (embryoma or Wilms' tumor). This tumor appears generally between the ages of 4 months and 4 years and is usually discovered by the mother at the time of diapering, dressing, or bathing, or by the physician during a routine health examination. There is painless swelling over the kidney region; there seldom are hematuria, fever, or other signs. These tumors are usually encapsulated and remain small for an unpredictable period of time; but once growth begins, it is at a rapid rate. As the tumor increases in size the capsule becomes tense and may even rupture. Parents should handle or touch the mass as little as possible, thus reducing the possibility of rupture, and should take the child to the physician at once for diagnosis and treatment. Delay may cost the life of the child.

The diagnosis of Wilms' tumor is usually established by x-ray films. The biopsy is contraindicated because of the high malignancy of the tumor and its early metastasis. This tumor is radio-sensitive. In some instances, it is treated first by x-ray and then removed surgically; in others, by surgery followed by x-ray. There does not seem to be a standard treatment but a nephrectomy is done as a surgical procedure. Silver[6] reports in his studies some survivals as long as two and a half to fifteen years after treatment.

5. *Bone tumors*. Osteogenic sarcoma and endothelioma (Ewing's tumor) are the most common types. These tumors are most common among males and occur most frequently in the second decade. Many bone tumors are difficult to diagnose in the early or late stages. The diagnosis, therefore, must be based on a careful history, physical findings, x-ray, and biopsy with histologic examination. Tumors of bone are so difficult to diagnose that even with x-ray studies and biopsies the prognosis is guarded.

Osteogenic sarcoma occurs most often in the femur, tibia, humerus, and other long bones but rarely in flat bones. Symptoms may be pain, impaired function, and fever. In the presence of osteogenic sarcoma, the serum alkaline phosphatase is increased and is a good corroborative test. Treatment most

generally employed is radiation followed by surgery.

Endothelioma (Ewing's tumor) arises in the long bones most often but flat ones may also be primary sites. Pain and swelling are the common symptoms in these tumors. Differential diagnosis is important because these tumors may be confused with osteomyelitis. The treatment is generally radiation therapy. Surgery is not usually employed.

6. *Leukemia* is considered a form of cancer because it is characterized by an abnormal growth or multiplication of cells. Although the disease may be acute, subacute, or chronic in children, acute leukemia is the usual variety, especially in youngsters under 5 years of age. Clinical findings are variable but may be enlarged lymph nodes and spleen; fever; pain in the long bones; dyspnea; pallor; and bleeding into the skin, into the mucous membranes, and occasionally profuse hemorrhage. Manifestations of leukemia are protean and, therefore, clinically it is easy to confuse it with bronchitis or other respiratory infections, tuberculosis, Hodgkin's disease, and others. Reliable diagnosis is based on peripheral blood studies, sternal marrow aspiration, or lymph node biopsies. Prognosis in children is very poor.

At this time the treatment of the disease is palliative. Such therapy as radioactive phosphorus, urethane, and nitrogen mustard has been carried out but with disappointing results. Farber[7] reports that aminopterin, a folic acid antagonist, used in his series of cases, showed remission but no cures.

More recently ACTH (pituitary adrenocorticotropic hormone) and cortisone (adrenal hormone) have been employed. After the first course of therapy the results have been reported as dramatic with improved appetite, higher morale, and a general feeling of well-being. Children themselves exclaimed, "I feel grand!" Like the treatment with aminopterin, remissions have been reported but no cures.

Parents, professional nurses, and others caring for the child with leukemia must expect an untimely end to life. The attitude of the person giving care is very important. Science has not found a cure, but newer treatments may lengthen life. What is done by way of research may give the child of the future a chance!

Attitudes

The pronouncement of cancer has such an impact that even stouthearted parents find it difficult to cope with their emotions. Since the day of birth there were dreams, hopes, and ambitions for the child, but suddenly these are frustrated. Immediately parents want to know: Will my child live? Will he have great pain? What type of treatment will be given? How much will it cost? It is the wise nurse who anticipates the strong emotional needs of the parent, hastens to bolster them by sympathetic understanding, and gives support during this period of great difficulty. These are therapeutic tools of top importance.

The child is the central point of the network of medical science applied in diagnostic procedures, treatment, follow-up, and rehabilitation. The young child is naturally fearful of the unknown, of physical pain, and of desertion by parents. Too, there are feelings of dependence upon parents and these are greatly exaggerated by illness. It often falls to the nurse to create a day-to-day climate of friendly understanding and support. Her attitude will be caught by the child as well as the parent and through her overt actions she will stimulate confidence and theoretically practice healing—the art and science of nursing.

The enterprising public health nurse will keep herself adequately equipped to work at top skill. She will keep up-to-date on research progress, knowledge of the disease, diagnosis, treatment, nursing care, rehabilitation, and resources. Frequent visits to the tumor clinic and tumor conference will help her to develop a sensitivity to predisposing factors, symptoms, body distribution, and the essentials of early casefinding. In the tumor clinic she will have opportunities to listen to patients' complaints, to observe the latest diagnostic technics and treatment methods and their effectiveness, and to become familiar with the admission and follow-up policies. Since many cancer patients are cared for in the home, observations of nursing procedures carried out in the hospital laboratory, x-ray

department, operating room, and at the bedside will help her to keep technical skills on a parity with scientific information. Regular attendance and energetic participation in cancer nursing institutes, inservice education programs, and lay meetings will advance her knowledge and that of others in the group. Constant reading of special articles in professional journals will help to reinforce and enrich her background thus enabling her to be more proficient in all cancer nursing activities.

The higher the cancer intelligence of the nurse, the more expertly will she be able to deal with her own attitudes and those of the parent and the child. She must be self-directing and actually apply knowledge to herself if she is to be an effective teacher. Her approach to patients should be gentle, understanding, but matter-of-fact. Her attitude should reflect her strong belief that cures are possible, that follow-up is essential, and that research holds out hope for the future.

Control

Effective cancer control measures can be applied even though the disease is not completely understood. Parents, teachers, nurses, and all professional workers should join forces in an all-out effort to reduce the high mortality in childhood. One of the most effective means is education. Everyone should know that cancer is not just a problem of maturity but is also a definite hazard to the child. Those responsible for children should be taught the signs and symptoms of cancer and that early diagnosis and prompt, adequate treatment may bring about favorable results. They should know that some cures of practically all types of cancer have been reported but that parents themselves must assist in discovering cases earlier if greater success is to be achieved. Parents should know the importance of the general periodic physical examination of well children and what it includes. The community should see that facilities are available for such examinations and that there is a strong educational program to stimulate parents to take advantage of the services made available.

Parents and nurses must recognize the fact that cancer in childhood is a serious condition and that the prognosis is grave. On the other hand, some children are alive today due to the application of present-day knowledge in cancer. Hope for a brighter future for the child with cancer lies in the extensive research now in progress.

REFERENCES

[1] Dorn, Harold F. Illness from cancer in the United States. Federal Security Agency, Public Health Service, 1944. Reprint No. 2537 from *Public Health Reports*, January 14, 1944; January 21, 1944; January 28, 1944. U. S. Government Printing Office, Washington 25, D.C. 10 cents. (Page 40.)

[2] Dargeon, Harold W. Diagnosis and management of neoplastic diseases in childhood. *The Medical Clinics of North America*, May 1947, v. 31, p. 498-524. (Page 523.)

[3] ———Cancer in children from birth to fourteen years of age. *The Journal of the American Medical Association*, February 14, 1948, v. 136, p. 459-468. (Page 459.)

[4] Nelson, Waldo E. (Editor.) *Mitchell-Nelson Textbook of pediatrics*. 5th ed. Philadelphia, Saunders, 1950. (S. Farber, page 434.)

[5] Dargeon, Harold W. Diagnosis and management of neoplastic diseases in childhood. *The Medical Clinics of North America*, May 1947, v. 31, p. 498-524. (Page 506.)

[6] Silver, H. K. Wilms' tumor (embryoma of kidney). *The Journal of Pediatrics*, December 1947, v. 31, p. 643-650.

[7] Farber, Sydney, and others. Temporary remissions in acute leukemia in children produced by folic acid antagonist, 4-aminopteroyl-glutamic acid (aminopterin). *New England Journal of Medicine*, June 3, 1948, v. 238, p. 787-793.

BIBLIOGRAPHY

Chipps, H. Davis. Cancer in childhood. *Northwest Medicine*, June 1949, v. 48, p. 408-410.

Farber, Sidney. Some observations on the effect of folic acid antagonists on acute leukemia and other forms of incurable cancer. *Blood*, February 1949, v. 4, p. 160-167.

Patterson, Mary G. Care of the patient with cancer. *Public Health Nursing*, July 1950, v. 42, p. 377-383.

Rector, F. L. Cancer in childhood. *The American Journal of Nursing*, July 1946, v. 46, p. 449-451.

McClure, Catherine T. Guest in the house. *The American Journal of Nursing*, December 1949, v. 49, p. 775-777.

Wolman, Irving J., Eglick, Paul, and others. Leukemia in childhood: preliminary report of response to aminopterin. *Pennsylvania Medical Journal*, February 1949, v. 52, p. 474-481.

Industrial Dental Programs

FRANCIS J. WALTERS, D.D.S.

PUBLIC HEALTH NURSES are ever seeking new ways and means of bringing health services to the people who need them. The industrial plant has been found to be a strategic place for the provision of adult health services in much the same fashion as the school serves as a health center for children. All public health workers including dental personnel recognize that industry affords an excellent opportunity for the application of preventive dentistry as well as preventive medicine. Casefinding can be carried out with comparative ease in such a convenient concentration of the adult population. Motivation for treatment through education is facilitated through group stimulus.

At the same time that health officials are recognizing their responsibilities in oral health programs, industrial management has shown an increasing interest in the oral health of its employees. While federal, state, and local health departments are continuing to extend all types of health services to industrial workers, both management and labor are seeking the various services which the health departments have to offer. To meet this increasing demand official dental health and industrial hygiene workers must work together in promoting oral health programs in plants within their jurisdictions.

By learning the objectives and functions of these programs, public health nurses can materially assist in their promotion and their accomplishment. It is the purpose of this presentation to depict for the public health nurse the present state of development of industrial dental programs as an integral part of all industrial hygiene activities.

Basically, the primary objective of all persons engaged in the field of industrial hygiene is to safeguard, improve, and help maintain the physical and mental health of the industrial worker. In working toward this aim physicians, dentists, nurses, statisticians, engineers, chemists, toxicologists, and other technicians are concerned not only with the specific diseases associated wth their industrial environment but also with nonoccupational illnesses which may account for a large portion of sickness absenteeism. Since oral affections are among the most prevalent diseases of man, the dentist working closely with other industrial hygiene personnel has an important function in the industrial hygiene program.

Federal Industrial Dental Program

Services aimed at the broad objective of optimal health for the worker are an integral part of the adult health program of governmental agencies. Through such services management and labor are assisted in the promotion of better health practices among the industrial population.

In the federal government the Division of Industrial Hygiene of the Public Health Service has the responsibility for developing programs to improve the oral health of industrial workers. This division has a staff of dentists who are trained in the recognition of the oral manifestations of occupational diseases and in the promotion of dental programs for the industrial worker. In collaboration with other specialists the dentists

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participate in clinical and laboratory studies to determine the possible effects of various environmental factors on the oral structures.

Through the industrial hygiene and dental divisions of state health agencies consultative service is extended to management, labor, and other groups concerned with the health of the industrial population. The range of this assistance extends from technical and administrative consultation to the provision of oral health educational materials for distribution to the worker.

State Industrial Dental Programs

The actual promotion of health programs and the making of surveys in industrial plants is undertaken by the state and local industrial hygiene units, which have the responsibility for maintaining the health of the workers in their area. For many years these units have been active in the promotion of in-plant medical services. They have recently been showing an added interest in extending their activities to include oral health services. These programs are now in their developmental stage and have found different types of expression in the various states. At the present time one state has a fulltime dentist as part of its industrial hygiene unit. In some of the other states the dental unit of the health department cooperates with the industrial hygiene unit in carrying out these functions. It is expected that this arrangement will become more prevalent since health officers are viewing with greater interest the promotion of in-plant oral health services.

American Dental Association standards

Responsibility for the improvement of the oral health of the industrial worker has also been recognized by the dental profession. As a guide to help public health workers at state and local levels in the development of industrial dental programs, the American Dental Association[1] has adopted a set of standards known as "The Essentials of an Industrial Dental Service":

1. The industrial establishment shall have an organized dental service, as further specified, with a competent staff including consultants and with adequate facilities to insure efficient care of all employees who need palliative emergency dental treatment because of occupational injuries or who have developed oral manifestations of occupational disease.

2. The dental department shall urge all employees to obtain necessary dental treatment and shall devote a portion of its time to educating them in the value of maintaining oral health.

3. The industrial establishment shall require thorough mouth examination of all persons entering employment. There shall be a system of complete and accurate records, filed in an accessible manner and available to the employee, to medical and dental services, and to government agencies for identification purposes. In setting up the records to be maintained the division of dental hygiene of the state department of health should be consulted in order that a uniform system of dental records may be developed that will make possible valuable statistical analyses and comparisons.

4. Membership on the dental staff shall be restricted to dentists who are (a) in good standing with the local dental society and (b) qualified in such fields as may be included within the service.

5. The dental department or service shall have complete responsibility for the dental personnel as to the quality of service rendered.

6. Industrial dentists should be familiar with the industrial processes and should watch closely for evidence of oral disease caused by such poisons as mercury, lead, phosphorus, fluorine, acids, and radioactive materials, and by other chemical or physical hazards. Immediately upon noting any oral evidence of occupational disease, other units in the industrial establishment, such as the medical department or safety engineering department, should be notified so that cooperative study and action may be undertaken.

7. The industrial dental service shall limit itself to the services specifically mentioned above. X-ray and prophylactic services in newly established industrial dental programs, however, and all details (not included in paragraphs 1 through 6) of services in operation at the time of the adoption of these rules shall require merely the approval of the state dental society.

Within the framework of these recommended standards state and local health workers promote in-plant dental programs. In carrying out such promotional activity they are assisted by information obtained from surveys to determine the dental need and dental diseases of occupational and nonoc-

cupational origin in the plant population. The data derived from these studies invariably show that nonoccupational dental diseases, such as caries and periodontoclasia, are more prevalent than diseases of occupational origin. Because of the wide prevalence of nonoccupational diseases and the possibility that the neglect of treatment may contribute to poor health, it is believed that they are of sufficient significance to merit a program for their correction and control.

In-Plant Industrial Dental Programs

The adoption of in-plant dental programs should be considered not only from the standpoint of controlling the diseases of occupational origin but also as a program for preventing oral diseases that are nonoccupational. The ease with which dental services are available directly influences the extent to which such services are utilized, and, of course, the success of the program depends on how much it is used. The worker will generally hesitate to take time from the job to visit a private dentist for palliative treatment. Therefore, he is more likely to take advantage of dental services offered at the plant if these are easily available.

Minimum in-plant services

The form of the program, however, is influenced by a number of factors, such as the size of the plant, the nature of the industrial processes, the geographical location of the plant, and the availability of outside dental services. Certain minimum services, however, may be considered basic for plants of all sizes. Heacock[2] has outlined these minimum required services within broad categories for in-plant dental programs as follows:

1. Preplacement and periodic oral examination and diagnosis of all employees.
2. Treatment and elimination of oral sepsis.
3. Emergency treatment and the treatment of occupational accidents and illnesses affecting the oral tissues.
4. Referral of the worker for further remedial and restorative care.
5. Dental health education.
6. Adequate recording of findings and recommendations.

In a general way the type of recommended dental service differs very little from the type of service recommended for the industrial medical programs. When such services are properly integrated with the plant medical program the dental findings contribute to a better understanding of the overall health status of the plant's working population.

Preplacement check

The first opportunity for medical and dental cooperation in the estimation of the employee's general health is presented by the preplacement physical examination. The oral examination at that time should include a careful clinical inspection, including the use of a mouth mirror and dental explorer, with a good light, and full mouth x-rays, where possible. If any corrective treatment is required the new employee should be referred to his private dentist for treatment so that he may start his job with a clean, healthy mouth. In this way oral pathosis will be less likely to contribute to future illness.

Periodic inspection

At periodic intervals, oral examinations should be repeated in order to observe any newly developed pathosis in its incipient, and therefore most curable, stage. In those instances where environmental factors may contribute to oral pathosis, a periodic inspection of the mouth will show local changes of the tissues that may have occurred since the preplacement examination. Control of the environmental factors may therefore be recommended before serious damage has occurred. Also, by means of such examinations preventive medicine can be practiced, for the oral cavity is in some cases a sensitive primary indicator of industrial toxic exposure that involves a systemic implication. In addition, the periodic dental examination offers an excellent opportunity to observe the extent to which the worker has obtained the recommended dental treatment.

Oral diseases of occupational origin and accidents should be treated in accordance with the provisions adopted by the American Dental Association and stated in "The Essentials of an Industrial Dental Service."[1] The

extent of the treatment for oral sepsis in an in-plant dental program may be determined by the nature of the sepsis. In the same manner that medical first aid is provided for acute ailments, such as headaches, cuts, and burns, the dental unit provides emergency treatment for toothaches and other painful oral lesions.

As in medical services industrial dental services generally do not include corrective treatment in the case of nonoccupational disorders. For example, permanent remedial dental operations, such as fillings, crowns, bridges, and dentures, necessary for the restoration of function or for esthetic purposes, need not be included in the services rendered by the industrial dental unit. Every effort, however, should be made to encourage the employee to obtain complete dental service on his own responsibility. Such a referral plan may be worked out with local private dentists in cooperation with the state dental society.

Role of the nurse

Both the medical and dental educational programs employ similar technics, such as the use of pamphlets, posters, films, and personal instruction. Individual education and motivation are particularly suited to the dental program. The industrial nurse is in an excellent position to assist in the educational phase of dental programs. Every time a worker seeks first aid, she has the opportunity to call his attention to the value of oral health and early treatment of dental disease. As stated by Dunning[3]:

> Whether or not there is a dentist actually employed on the plant premises the industrial nurse can be of great assistance. Where the dentist is available she can route cases to him, often recognizing a dental cause where patients complain of sinusitis, headaches, or a variety of symptoms in the region of the mouth. Where dental service does not exist she can increase her casefinding activities by being on the watch for bad teeth among those who do not regularly visit their own dentists. She can locate dentists in the community who will be willing to take care of dental emergencies arising in the plant and particularly locate an oral surgeon to be available in case of jaw injuries. Often she can render dental first aid [in accordance with standing orders from the Dental Society]. There are a number of times where simple dental treatment of a first aid nature will give great relief without prejudicing the work of the dentist later on. An aching tooth which is not yet tender to bite upon may easily be relieved by the insertion of an extremely small cotton pellet soaked in eugenol.

Regardless of how limited or broad the plant medical program is—whether it includes only nursing services or encompasses medical and dental services—the nurse can play an important role in educating the worker, and thus indirectly his family, about the value in periodic dental care.

Medical and dental records should not be kept separately. When the records are limited to the findings of the dental examination the information is not sufficient to obtain a true picture of oral conditions, their causes and physical implications. This information alone will not enable the reviewer to obtain a meaningful correlation with the medical data. For example, the dentist has an excellent opportunity to observe an excessive degree of salivation. When this information is entered in the dental record and available to the physician it is possible to correlate this finding with other physical findings wherein an early diagnosis of mercury poisoning may be made. Therefore, when possible, the dental records should be a part of the individual's medical record and should be available to both the medical and dental services.

Benefits of In-Plant Dental Programs

The benefits derived from industrial dental programs functioning in a community are numerous. Puffer and Sebelius[4] reporting on a study of absentee records in Tennessee plants state that: "the [annual] frequency rate for absences of 1 calendar day or longer as a result of diseases of the teeth and gums was 47.3 per 1,000 employees and the disability rate was 0.210 day per employee. The severity rate of 4.4 days per absence indicated that many of these absences were caused by serious illnesses that resulted from dental conditions. The rate for absences lasting 8 days or longer of 5.7 per 1,000 employees was evidence that serious illnesses are due

to dental causes." From an economic point of view management has much to gain from such a program, for a worker's absence from the job to obtain emergency dental treatment may be costly in many ways. First, there is the direct loss of the individual's absence from work. Second, his absence may require some adjustment in the work schedule of fellow employees. Third, time may be lost in arranging for and training a temporary replacement. In addition to a saving of time and money management enjoys a greater share of employee good will to which in-plant dental programs as well as other health services contribute.

The value of in-plant dental programs to the worker is equally beneficial. A study made in the Brooklyn Navy Yard[3] during the recent war showed that "palliative emergency treatment to relieve acute dental conditions saved 5.3 hours where disabling cases were returned to work. This figure represents the time the employee would have lost 'on excuse' from the Navy Yard the first day alone in order to secure outside treatment. Sixty percent of the emergency cases seen in this dental service were returned to work after brief treatment. Twenty-seven percent more were 'false alarms' and were also returned to work. Only thirteen percent of the emergency cases needed to be sent home." Thus, the worker benefits by not having to take time off to obtain any necessary emergency treatment that could be provided by an in-plant dentist. From the standpoint of preserving employee health an in-plant dental program, through periodic examination, helps protect the worker from occupational oral diseases. Through these examinations the worker also learns of disease conditions unrelated to his job for which he may seek private treatment. By obtaining such care for himself and possibly his family he learns how he may improve his general health through proper dental care. In-plant dental programs thus have numerous beneficiaries, ranging from management to the individual worker and all of the members of the community.

BIBLIOGRAPHY

[1] American Dental Association, Committee on Economics. Dental service in industry. *The Journal of the American Dental Association*, February 1942, v. 29, p. 299-301.

[2] Heacock, L. D. Dental relations in industrial health services. *Industrial Medicine*, January 1947, v. 16, p. 5-9.

[3] Dunning, J. M. Dental service in industry. *Health at Work, a Publication for the Industrial Nurse*. Liberty Mutual Insurance Company, Boston, Mass. No. 17, p. 1-3.

[4] Puffer, R. R., and Sebelius, C. L. Absenteeism in Tennessee industrial plants caused by diseases of the teeth and gums. *The Journal of the American Dental Association*, September 1, 1946, v. 33, p. 1122-1131.

New Social Security for Nurses

(Continued from page 637)

ization and recorded by the Social Security Administration. The amount deducted from the earnings of employees, together with the employer contribution, will be sent with the report. (Deductions for social security will be separate from income tax deductions.) The only information required by federal officials concerning any individual employee will be the name, social security number, and amount of wages or salary paid during the calendar quarter.

Obviously, the new provisions for extension of federal old-age and survivors insurance will not result in coverage of all public health nurses. But the door to coverage is open to many who have until now found it closed. To that extent, the new legislation is further recognition of the public health nurse's contribution to the nation's welfare.

The Public Health Nurse in England Today

P. JEAN CUNNINGHAM, S.R.N., S.C.M.

WHAT HAS THE NATIONAL Health Service Act meant to the English public health nurse? Has the scope of her work increased or have the revolutionary measures in the field of health in England meant little change to her? I think that in general the work of neither the health visitor nor the district nurse has been changed radically since the act came into force in July 1949, although the district nurse is finding more patients who require her care at home. This is partly due to the increased pressure put on hospitals.

A patient probably stays longer in hospital in England than in America. He is kept in the hospital until he is able to be about again and even then he may be sent on to a convalescent home. In 1938 the average stay of a patient in the 159 hospitals of all varieties in the London area was 19.1 days; in 1946 and 1947 it was 18.7 days. No later figures are available. (*Editor's note*: The length of stay in general nonprofit hospitals in the United States in 1946 was 9.6 days; in 1947, 9.0 days.)[1] There are plans afoot, tried out in Cambridgeshire, for discharging the patient from hospital as soon as the acute stage is over and referring him for further care at home by the visiting district nurse. However, there is a shortage of district nurses as well as of nurses in all other fields and the plan cannot be developed beyond the nursing resources of a particular district.

Midwifery in the home is undertaken by district nurses who are trained midwives, and recent statistics show remarkably good results. In 1948, 69,380 mothers of whom over 21 percent were primiparas were delivered at home by midwives. The maternal deaths were 48, a maternal mortality rate of .69 per thousand. In the same year there were 31,396 maternity cases attended at home by a midwife and doctor. Before the National Health Service Act the midwife delivered many babies without the attendance of a doctor. Since the act came into force more mothers have had a doctor booked to attend them, whether they required him or not, but it is felt by many that the midwife should be encouraged to deliver her own cases unless there is definite need for the doctor to be called in.

Under the act the newly constituted Local Health Services Executive Committee became responsible for midwifery and home nursing. The district nurse is no longer employed by the village district nursing association with its committee of local people but by the local authority, such as the London County Council. In many cases the local authority still makes use of the old voluntary committee but it bears the main financial responsibility.

THE HEALTH VISITOR—a trained nurse without her exact counterpart in most other countries—has theoretically had the scope of her work vastly increased as she

[1] Arestad, F. H., and M. G. Westmoreland. Hospital service in the United States. *Journal of the American Medical Association*, April 12, 1947, v. 133, p. 1065-1082.

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now has to care for the whole family. However, since there is still a shortage of health visitors, her day-to-day work has not actually changed very much. Although health centers are envisaged for the future it is hoped that the health visitor will not become a "clinical hack for the general practitioner" but will be able to develop her work in the prevention of ill health by her home visit, the most important part of her work. She is a nurse with midwifery experience and public health nursing training, and one of her chief responsibilities still is maternal and child welfare. The health visitor does not give actual bedside nursing care. In towns, she visits all the new babies in her area when they have returned home from hospital or when the midwife has finished her care of the child, usually two weeks after birth. She visits all the children in her district until they are five years of age when they go to school and gives advice on health problems. In country districts, she is also the school nurse and tuberculosis visitor, and in more rural areas she may also be employed as the district nurse who gives actual nursing care. With her new duties under the National Health Service Act the health visitor must care for the old people in her district and she must help in selecting patients for admission to a suitable hospital for the chronically ill.

The health visitor has been called "a general practitioner in health" and although her work is not spectacular it is of tremendous value to the people of the community, to whom she has become the family friend and one from whom they can seek advice on a professional basis.

Maternity Care in Great Britain

MARGARET BROOKSBANK, S.R.N., S.C.M.

FOR FIFTY YEARS the Government of Great Britain has been increasingly interested in improving maternity care. Four Acts of Parliament were passed between the years 1902, when the Central Midwives Board was established, and 1936. The Midwives Act of 1936 was almost revolutionary in that it empowered all local authorities to provide an adequate service of trained midwives to women desiring such service during childbirth and the lying-in period. This act also prohibited any other person from acting in the capacity of midwife for gain but continued to allow state registered nurses to act as maternity nurses under direct supervision of a doctor.

These four acts constituted the foundation of a highly protected and regulated profession which has today 73,000 certified midwives registered. Of this number, 17,000 are practicing midwifery. These midwives are responsible for 65 percent of all deliveries, both in and out of hospitals, and they are in attendance at 98 percent of the total number of deliveries.

Today, the midwifery service is part of the National Health Service, still organized and administered by local authorities but coordinated in that wide scheme considered by so many Americans as revolutionary. Many of the services functioning as part of the National Health Service have been giving valuable help for many years as volunteer agencies. Among these is the Queen's Visiting Nurse Service, started in the Reign of Queen Victoria.

Miss Brooksbank is matron of the Lordswood Maternity Hospital in Birmingham, England. *This paper is based on the talk Miss Brooksbank delivered at the meeting of the* NOPHN *Nurse Midwifery Section during the Biennial Nursing Convention in San Francisco in May 1950.*

According to the Report of the Chief Medical Officer of Health for 1949, the needs of the maternity patient are:

1. Routine antenatal care, including medical examination.
2. Educational preparation for motherhood.
3. Wassermann and Rh blood-testing.
4. The service of the midwife during pregnancy or for the confinement, backed by medical help in the case of need.
5. Postnatal care of the mother and baby by the midwife and, when necessary, by a doctor.
6. A final medical postnatal examination.
7. The services of a consultant and, if required admission to hospital during pregnancy.

From my own experience, I believe these needs are being met.

Forty-five percent of the women in England and Wales are delivered in their own homes. When the woman believes that she is pregnant she first consults with her own family physician. If he advises it is safe for her to plan for a home delivery, she usually engages a midwife unless her physician wishes to give her complete supervision and care. After a patient chooses her midwife she sees the patient regularly throughout her pregnancy, helping and advising in the preparations to be made for confinement as well as being responsible for the patient's welfare. From time to time, the midwife will receive reports from the patient's own doctor or the doctor at the Welfare Center. Every effort is being made to ensure that services in the home will equal those in the hospital. The midwife arranges for physical examinations by the doctor. She may accompany the patient to the physician's office or clinic, or the physician may examine the patient at her own home or at the midwife's office, which is usually her home.

At the thirty-sixth week of pregnancy, the midwife must obtain a certificate from the patient's doctor, stating that the patient is medically fit to receive nitrous oxide and air analgesia. The relief of pain in childbirth has been—and continues to be—a subject of tremendous interest in research; and still we find mothers who are reluctant to accept any form of relief. We try to overcome this prejudice by teaching them how to use the simple machine, showing them that it is impossible to become anesthetized, as the flow of gas is controlled by valves which allow the air to enter when the small bag contained in the body of the machine is empty. Furthermore, the patient herself controls the intake as the machine is specially made for self-administration. The most important thing to the patient is the fact that it has no ill effect on the baby. Years of widespread use and observation prove this.

For some time now, classes have been given at the prenatal clinics to help the patients prepare themselves for the tremendous and exciting experience of childbirth. Fast disappearing is the frightened and anxious girl who used to be admitted to hospital; rather it is a responsible woman, doing a responsible job for which she has been well trained. During the war, demonstrations in cooking were given in clinic waiting rooms. These are being carried on in some places, and afternoon sewing classes are a regular feature. Fathers' classes, too, have been set up, but the men are rather shy and it is difficult to get them together.

Although 45 percent of the women in Great Britain have their babies at home, they do not suffer by it. Dare I say, they have a greater advantage. The baby is accepted at once; the mother is not separated from her family and husband at a most crucial time; the father shares the experience to a greater extent and later remembers with pride his wife's fine behavior during her labor. Added to this, the patient has the services of a highly trained midwife, her own doctor if required, and in an emergency where it would not be to the patient's advantage to be moved, such as postpartum hemorrhage or obstetric shock, an obstetric flying squad is available. This team has as personnel a specialist obstetrician, an experienced nurse-midwife, a medical student, and at home the patient's own doctor and midwife. The advantage of such an arrangement can be judged by the result. In the City of Birmingham, with a population of nearly one and a quarter million, there was no death from postpartum hemorrhage in 1948.

(Continued on page 662)

Integration of Social and Health Aspects of Nursing in the Basic Nursing Curriculum

A SUBCOMMITTEE of the Committee on Curriculum, serving as the Education Committee of the Michigan Nursing Center Association, has prepared a manual on integration. The following material is abstracted from the manual with the permission of the MNCA.

Goals

The following specific goals of any total program in nursing education will be developed and strengthened by the curriculum which integrates the social and health aspects of nursing:

1. Enlarged understanding and appreciation of people as individuals and as members of families in the community.

2. Increased ability to identify patient needs and to meet as many of the nursing needs as possible within the framework of the hospital and the community.

3. Increased knowledge of the factors which contribute to health and which prevent disease; ability to apply this knowledge to the student's pattern of living and to help the patient to understand and utilize such knowledge in regaining and maintaining his health.

4. Increased ability to carry on purposeful conversation with patients.

5. Ability to plan for continuity of nursing care with the patient and his family, and with other professional people who can contribute to such care.

6. Familiarity with and increased ability to use sources of information about available resources in the community which might meet specific patient needs.

7. Recognition of the limitations of nursing and the need for good working relationships with other health and welfare workers.

8. Awareness of the special fields of nursing which have as their primary goal the promotion of health and the prevention of disease.

Principles on Which Any Plan For Integration Is Based

1. Provision for better care to patients is the chief aim.

2. Provision of the type of nursing service which includes the social and health aspects is a responsibility of all nursing and hospital and agency personnel and is not to be regarded merely as an educational tool.

3. Provision of a curriculum with emphasis on the social and health aspects of nursing throughout all its phases is the responsibility of the school of nursing faculty.

4. The integration of the social and health aspects requires the coordinated effort of all concerned. Nursing service must recognize its responsibility in meeting total nursing needs and its stake in the goal of improved patient care. Each instructor must share responsibility with instructors in other fields and each must understand what the others are doing. Administration must lend practical support.

5. Public health nursing agencies have a definite responsibility for helping to promote the type of patient care and nursing education which includes the social and health aspects, and for sharing available personnel and/or facilities to this end.

6. Any successful plan for integration requires, on the part of the school faculty, an understanding of the principles of public health nursing, an ability to identify total patient needs, and a usable knowledge of resources to meet these needs; and, on the part of public health nurses who participate in the

educational program, knowledge of current hospital nursing practice, understanding of modern nursing education, and familiarity with the curriculum of the school with which they are working.

7. Education which includes the social and health aspects of nursing does not necessarily imply student experience outside the hospital situation. The rich opportunities within the hospital can be utilized to increase the student's understanding of the individual needs of patients and the community resources which aid in meeting them. This implies close coordination of the various services within the hospital and effective relationships and understanding between hospitals and other community agencies.

8. Observation in public health nursing or other community agencies is only one of the many ways of bringing about the integration of the social and health aspects of nursing into the total curriculum. In some areas, the goals may have to be sought within the hospital entirely, with the aid of public health personnel employed by the school or engaged in community health work. Each school of nursing will need to study its own resources and other available community resources which contribute to better patient care and student education.

9. Carefully selected observations in community agencies, adapted to the student's needs and interests, well correlated with her experiences as she moves along developing nursing skills, and well supported by preparatory and evaluation conferences are of sounder educational value than an isolated block of work experience in a public health nursing agency.

10. Any arrangement for participation of individuals or agencies outside the school in the educational program of the student should be confirmed in writing, stating terms of the arrangement and responsibilities of each party.

Enrollments

A total enrollment of 3,503 students in educational programs for graduate nurses approved for public health nursing by the National Nursing Accrediting Service was reported by thirty-one colleges and universities to the NOPHN in March 1950. Most of the institutions reported information for the spring 1950 session.

Of the total enrollments, 1,354 were fulltime students and 2,106, parttime. One university with 43 enrollees did not report a breakdown. Most of the schools classify students taking 12 or more semester hours of work as fulltime and those taking less as parttime.

In comparing the enrollments with the same period of the previous year, most of the schools did not differentiate between parttime and fulltime students, merely indicating that the enrollment was larger, smaller, or the same.

Reasons given for larger enrollment were: better means of recording number of parttime students; natural growth of school; requirements made by state department of health for public health nursing education for staff; changes in the arrangement of courses; arrangement for parttime students; revision in program of study making possible the division of students into two groups for field work; more graduate students; increased interest in public health nursing.

Reasons given for smaller enrollments were: the withdrawal of a new course, "Geriatrics"; a natural fluctuation in parttime students; reduction of students receiving benefits under Public Law 346 (G.I. Bill of Rights); no students on stipend from the state board of health; a decrease in courses offered; fewer foreign students; inability of students to attend because of work loads.

Thirteen schools attributed a drop in enrollment to economic factors, the most common being a reduction in students receiving G.I. benefits.

—M. O. D.

Towards Equality of Opportunity

EDWARD W. EDWARDS

The New York State Commission Against Discrimination chalks up gains in nursing and other fields.

THE NEW YORK State Commission Against Discrimination has made remarkable progress in protecting the rights of nurses in regard to discrimination in employment on the grounds of race, creed, color, or national origin. Many nurses are, of course, employed by certain hospitals or organizations over which the commission has no jurisdiction. The law under which the commission has operated for the past five years clearly excludes from the commission's jurisdiction a club exclusively social or a fraternal, charitable, educational, or religious association or corporation, if such club, association, or corporation is not organized for private profit. However, although the majority of the hospitals do not fall within the commission's jurisdiction, many have waived the matter of jurisdiction when the commission has received verified complaints against them, and have requested the commission to judge the cases in question on their merits.

Just for the record, here are some statistics concerning the activities of the commission in the nursing field:

Since its beginning in 1945 the commission has handled some fifty-three regulatory matters concerning employment discrimination based on race, creed, color, or national origin in public health institutions, and thirty-three verified complaints affecting nurses have been filed. In addition, thirteen commission-initiated investigations into various medical institutions have been conducted, and the employment application forms of seven health organizations have been reviewed for discriminatory questions. Although these investigations and complaints involved hospitals primarily, other organizations, such as homes for the aged or blind, nursing homes, and private sanatoria, were included.

Because of the exemptions provided under the law, it is probable that many nurses know comparatively little about its operation. Therefore, it might be of interest to discuss briefly how the law works.

A Pioneering Measure

July 1, 1950, marked the fifth anniversary of the New York State Law Against Discrimination. This law, coupling the use of education and sanctions, where necessary, in the prevention and elimination of job discrimination, was the first statute of its type to be passed in the United States. Today after five years of operation, it is no longer an experiment in social legislation but a real instrument of social progress. It has been the model for similar laws in seven other states: New Jersey, Connecticut, Massachusetts, Rhode Island, Washington, Oregon, and New Mexico. It has also been the pattern for municipal ordinances in Minneapolis, Minnesota; Philadelphia, Pennsylvania; Phoenix, Arizona; Richmond, California; and Cleveland, Ohio.

There has been tremendous interest all over

Mr. Edwards is chairman of the New York State Commission Against Discrimination.

the country in the commission's experience. Many Americans who were sincere advocates of civil rights for all and who were working for amicable intergroup relations had opposed passage of the New York law. They feared that this effort to regulate and control employment practices by legislation, this attempt to modify long-established habits and customs, would fail, thereby retarding rather than advancing the cause of civil rights.

Today such fears have almost completely disappeared. The experience of the commission shows that such a law can be administered without intimidation and harassment of employers, unions, and employment agencies, without an increase in intergroup tensions, and without danger to the order and stability of business.

How the Law Works

The detailed provisions of the law are based on the legislative finding that "practices of discrimination . . . because of race, creed, color or national origin . . . threaten not only the rights and proper privileges of its inhabitants, but menace the institutions and foundations of a free democratic state." The statute defines the opportunity to obtain employment without discrimination as a civil right and provides the administrative machinery—a five-man, fulltime, salaried commission, appointed by the Governor—to insure to all people the enjoyment of this right. This commission has two major functions:

1. To prevent and eliminate discrimination in employment, whether by employers, labor organizations, employment agencies, or other persons.
2. To develop a positive educational program in all fields of human relations.

In executing its first function the commission receives, investigates, and passes upon complaints alleging discrimination in employment on the part of employers, labor unions, employment agencies, or others. In processing such matters the commission adheres strictly to that section of the law which provides that if investigation of the complaint results in a finding of probable cause, an effort shall be made immediately by the investigating commissioner to eliminate the alleged discriminatory act. He calls conferences and attempts conciliation and persuasion before resorting to a public hearing and the issuance of a legal order.

Verified complaints constitute the major part but only one phase of the commission's regulatory work in the employment field. Other facets of commission operation are:

1. Commission-initiated investigations and studies of employer, labor union, and employment agency policies and practices.
2. Inspection of employment application forms and newspaper advertisements.
3. Industry-wide conferences of an educational nature.
4. Organization and activation of industry-wide liaison committees to assist the commission in its regulatory and educational work.
5. Collaboration with other state departments on matters outside the enforcement jurisdiction of the commission but within the purview of such other state departments.
6. Processing informal complaints and inquiries and taking appropriate legal or educational steps in resolving such problems.

Achievements in Preventing Discrimination

The use of the above technics has resulted in far-reaching changes in employment policies and practices within the state. The gains described below are illustrative.

In a railroad industry

Transportation agencies, particularly the railroads, no longer confine certain groups to menial occupations. The principal railroads of the state have reframed their policies to eliminate discriminatory employment practices. Illustrative of this was the action of the New York, New Haven, and Hartford Railroad Company which, cooperating with the New York and Massachusetts commissions, eliminated the practice of restricting grill car waitress opportunities to white persons. It has also eliminated discrimination in the occupations connected with the manual handling of railroad freight, and in related clerical jobs.

In the white-collar field

Opportunities for Negroes and members of certain religious groups have been considerably expanded in the white-collar and clerical fields. This change is particularly noticeable in the sales field. Negroes are now employed in sales and other white-collar positions in the largest department stores of the state's major cities.

The commission's role in bringing about this change is illustrated by the handling of this case. A complainant alleged that a large mail-order house had refused her employment as a file clerk because of her color. After a detailed investigation a conciliation agreement was arrived at and the respondent agreed to reinterview the complainant. This resulted in the applicant being hired. A review after six months showed that this worker had been given two increases in salary. The investigator also found that the firm had employed thirty-three Negroes for clerical jobs.

Regarding the employment of Negroes in white collar positions, the following statistics are pertinent: In 1940 only 3 percent of all Negro women employees in New York City had sales or clerical jobs. In 1947 that figure reached 13 percent and there is indication that the 1950 census figures will show a tremendous upward trend.

In railroad unions

A commission investigation of thirty unions in the railroad industry revealed that fourteen had constitutional clauses limiting membership to members of the Caucasian race. As a result of commission action these clauses were rescinded or made inoperative within the state. As of today, there are no unions operating in the state, either in the railroad or any other industry, which maintain such membership provisions. Moreover, the so-called auxiliary lodges into which Negroes were segregated without full privileges of membership have been abandoned.

In preemployment questions

Preemployment questions which directly or indirectly reveal race, creed, color, or national origin have been almost completely eliminated from employment interviews, application forms, or specifications in newspaper ads or classified advertising directories. Studies in states not having a fair employment practice law show that the practice is still quite widespread. The commission has not merely ruled that certain questions are unlawful but has consulted with employers and employment agencies in order to develop substitute questions which elicit the desired information without violating the law.

The use of discriminatory copy in advertisements of employment agencies appearing in classified telephone directories was eliminated after a series of conferences between the commission and officials of the New York Telephone Company. Employment agencies having national designations as a part of their firm name are now using an explanatory legend such as "non-discriminatory" as an assurance to the public that their employment agency services are rendered on an equal basis to members of all groups.

Gains through Education

In fulfilling the second of its functions, educational work, the commission has utilized all the media of communication: radio, television, movies, pamphlets, and school, church, and civic agency programs. Further, it has organized community councils throughout the state to study the problems of discrimination in all or specific fields of human relations. The purpose of these councils is to foster good will, cooperation, and conciliation among various groups within the state and to suggest to the commission programs of formal and informal education in the field of human relations which the commission may recommend to the appropriate state agency. Such councils, made up of representative citizens serving without pay, now function in Albany, Syracuse, Buffalo, Manhattan, Troy, and in Broome, Richmond, Kings, Queens, and Westchester Counties. No attempt has been made to foist an educational blueprint on any community, but the commission has provided its councils with technical advice and educational tools. Utilization of these may develop answers to intergroup problems which, if not solved, would weaken the structure of the state.

It Has Been Effective

After nearly five years of operation, has the New York State Law Against Discrimination been effective? Competent students of the law have observed that remarkable strides have been made towards preventing and eliminating job discrimination in the state. The *New York Herald Tribune* stated editorially on March 28, 1949:

> Legislation against discrimination in employment is practical and successful. This is common knowledge in New York; the evidence is everywhere plain. There were serious doubts when our State Commission Against Discrimination began operations in 1945, but the subsequent record is one of expanding progress. The achievements have been many and precise, and the New York State Commission is so well established and recognized that it is now taken as a model in other forward-looking cities and states.

The foregoing résumé illustrates what can and has been done through skillfully devised laws in eliminating and preventing discrimination based on race, creed, color, or national origin. Such laws represent, in the areas of employment, education, and housing, a new method for solving the age-old problem of interpersonal and intergroup relations. Though they invoke the power of the state where overt acts of discrimination take place, they are primarily instruments of democratic community education and activity. They represent a coupling of education and force, where necessary, in the job of bringing equality of opportunity to all. They have enlisted the cooperation and purposeful activity of many community agencies—public and parochial schools, churches, and civic, veteran, labor, and other organizations working with minority groups.

The commission has constantly emphasized that the law is not directed against any group and is not administered for any special groups but is a resource of the state designed to bring benefits to all the people. Adherence to this policy has not completely eliminated discrimination in the state, but it has reduced the incidence of discrimination and has developed employment opportunities for minority groups in certain fields hitherto barred to them by unfair practices.

With the continued cooperation of all citizens, the State of New York through effective administration of the law should continue to exercise an important role in bringing about understanding and friendship among all the racial, religious, and nationality groups that make up its diversified population.

FAIR EDUCATION PRACTICES LAW

Recognizing the inadequacy of civil rights laws which prohibit educational discrimination without providing administrative machinery for enforcement, the citizens of three states have secured enactment of fair educational practices legislation: New York (April 1948), New Jersey (April 1949), and Massachusetts (August 1949). This type of legislation, which was recommended by the President's Committee on Civil Rights, is modeled on the more widely-known fair employment practices laws. In New York, the act is administered by the Education Practices Administration, a division of the state Education Department; in New Jersey, by the Division Against Discrimination, the agency within the Department of Education which is empowered to administer the fair employment and other public accommodations legislation as well; and in Massachusetts, by the Office of Director for Fair Education Practices, which is within the Department of Education and subject to the direction of the Commissioner of Education.

The laws prohibit exclusion, limitation, or discrimination in admissions on account of race, religion, creed, color, or national origin, and in Massachusetts, discriminatory questions on application forms are specifically designated as an unfair practice. Although the New York law applies only to public institutions of post-secondary grade, each of the other acts includes all non-private schools from primary through university levels. Religious and denominational schools are exempted from the provision of each of the acts insofar as the ban against selection on the basis of religion is concerned.

—From the *Report* of the American Council on Race Relations, June 1950.

Christmas in Alaska

Bertha L. Bloomer, R.N.

THERE WAS A BUZZ of activity in the village as the plane circled again and again. Little tots, looking as wide as they were high in their winter togs, appeared here and there squealing with excitement, for the Christmas trees were coming! Lashed securely under the wings of the circling plane were the first trees for Naknek's Christmas celebration, flown by the bush pilot from the wooded areas miles from the village. No trees grow on the barren, wind-swept tundra surrounding Naknek, but the evergreen is as much a part of Christmas to the villagers as it is to people Outside, and the bush pilots saw to it that no family was without one. Two especially nice large trees were chosen for the school and the church, and the rest were propped in the snow against the schoolhouse for the villagers to choose. When the trees arrived everyone knew that Christmas was just around the corner.

But the feel of Christmas really came to Naknek much earlier when the Sears Roebuck and Montgomery Ward Christmas catalogs first appeared in the post office, for the "wish books" were Santa Claus for the 175 winter residents of the village. The small children leafed through the toy sections until the pages were dog-eared, while mothers and fathers listened carefully to their exclamations of "I want Santa to bring me this," and secretly made out orders after the youngsters were in bed. Little Mary's mother may be making her a new fur parka and mukluks (fur boots) for Christmas the way native mothers have been making them for generations, but Mary will probably also get that gay Sears Roebuck dress she wants to wear to the Christmas program. The children of Naknek—some Aleut, some white, a few Eskimo and Indian—are just like children Outside in their Christmas wishes, even though many have never been to a village larger than Naknek. The little girls want the rubber dolls that can be bathed, fed, and diapered. The boys want ice skates, sleds, or skis. Model airplanes and little metal or plastic planes are bigger favorites than cars or trucks or trains, for Naknek is an airminded village where it is the usual thing to see nine or ten small planes parked along the shores of the airplane lake.

There was much activity in Naknek as Christmas drew near. The delicious odor of Scandinavian cookies and cakes greeted each visitor as he opened the door of almost any home. Washing and ironing, scrubbing and sweeping went on at a great rate, for everything had to be spotless for Christmas.

Miss Bloomer, before becoming maternal and child health nursing consultant, Alaska Department of Health, was public health nurse midwife in the Bristol Bay area of Alaska.

In spite of all the Christmas preparation in the village, the work of the health center went on. Dark-skinned, brown-eyed preschoolers took their diphtheria, pertussis, and tetanus "shots" even more willingly than usual, for they had heard that Santa brings toys to the good children. Expectant mothers stopped at the health center for their prenatal examinations before hurrying home to finish wrapping some Christmas toys while the children were at school. Child health conferences were bigger than ever, for families from other villages who came to Naknek to shop or visit always stopped at the health center. There was the usual quota of sick calls to be answered and cuts to be patched up, but no one seemed to have time to stay sick with Christmas so near.

Little Josy had to make her usual trip to the health center for eye treatment. Josy's inflamed eyes, like the eyes of so many other children in this area, were already badly scarred. All one could do was to try to prevent further scarring and complete blindness. Young Gust, who spent many of his after-school hours hunting ptarmigan for his foster family, sat stoically in the clinic chair while his chin, lacerated when he fell on the ice-covered tundra, was stitched up. Old one-armed Nick, from Sevonosky village up the river, brought his dog sled to a stop outside the health center and helped his wife and their two foster children out of the sled. I always enjoyed their visits to the health center, although Mamma Nick did not know any English and Nick spoke English with much difficulty. Nick always stopped at the health center when he came to Naknek and made extra trips to the village whenever he heard that a doctor was holding a clinic or a special team was taking x-rays or giving special inoculations at the center.

THE BUSIEST PLACE of all in Naknek during the Christmas season was the schoolhouse. The children were occupied for weeks ahead of time making Christmas gifts for their mothers, fathers, sisters, and brothers, cutting bright-colored decorations for the trees, and making costumes and scenery for the Christmas program. The school program was awaited with all of the anticipation afforded the opening night of a Broadway show since it was the big social affair of the year. For weeks before Christmas little round-faced, brown-eyed Nancy repeated her Christmas poem until she said it in just the right way. Herman, an alert young Eskimo boy with a definite talent for music, practiced his piano solo diligently on the school piano, for he wanted to do especially well the first time he played in public. Every child had a part in the program—from little firstgraders to almost grown-up eighthgraders, from tow-headed, fair-skinned, blue-eyed George and Sharon and John and June to black-haired, brown-eyed, dark-skinned Gust and Peter, and Josy and Hans and all the rest.

As much as I enjoyed being a part of the Christmas preparations at Naknek, I had a field trip to another village to make and I had to go while the weather permitted. As we took off I was wondering whether I would get back to Naknek for Christmas. When we reached the village which was our destination we circled several times until we saw one of the villagers go out to a dog sled and begin hitching up his dog team to come out to the lake where the airplane would land. By the time I reached the schoolhouse everyone in the village had heard via the "mukluk telegraph"—Alaska's amazing word-of-mouth communication system—that I had arrived. Almost before I had my bags unpacked people began arriving at the schoolhouse for immunizations, prenatal examinations, well child conferences, for general advice on how to stay well, and for instructions on what to do for those who were ill or injured. Everyone wanted to see me the first hour I was in the village. It was with some difficulty that I convinced them that if they came at an appointed time later they would be certain to be seen. I took care of as many of the mothers with babies as possible so they would not have to make another trip carrying their little ones on their backs. I have always been fascinated by the skill with which the mothers slide the young babies down from their backs and out from under the parkas to be undressed and examined at the well child conferences. I am even more amazed at

the way each mother bounces her baby onto her hip, slips him up under her parka, bending at her waist to slide him up into the parka hood when she is ready to go home again.

The interest which these parents expressed in the health of their children was gratifying. They seemed eager to have any advice or suggestions and in spite of the language barrier which existed between us in many instances, we managed to understand each other fairly well by using many gestures. The patients always laughed delightedly at my poor attempts to try out my meager vocabulary of Aleut.

I worked steadily during my stay in the village—in the school, in the homes, and in the makeshift health center. There was much to be done and my time was limited for this was only one of the fourteen villages, scattered for two hundred miles along the shores of Bristol Bay and Illiamna Lake, which I visited. I had to leave all too soon. There was a break in the weather one day and the pilot arrived, suggesting that I should leave that day if I did not want to risk being weathered in for a month.

It was four o'clock in the afternoon and almost dark when we flew over Naknek village. Although the village looked drab and lifeless from the air, it seemed friendly to me. When the plane landed children appeared here and there to help me carry my bags into the village. Each tried to outdo the other in telling me what had happened in the village during my absence. In a few minutes I was up to date on all the news. The mail plane had not yet arrived and it was only two days until Christmas. Most of the families had not received their orders from Sears Roebuck and Montgomery Ward, so if the mail plane did not arrive before Christmas many of the children would have few gifts. All the way to the village the children babbled about the school program, visitors, Christmas gifts, hunting and trapping. It was good to be back in time for Christmas.

MUCH HAD HAPPENED during my absence. The Christmas program was shaping up. Families from the neighboring salmon canneries had arrived for the holiday. Bewhiskered trappers, looking like strangers to me with their unfamiliar beards, had come into the village from their isolated trapping cabins by dog sled, plane, skis, or snowshoes. Wherever people got together there was much discussion about the trapping season. Some claimed that this was not a good season for mink, while others said they had never known a better one. All the trappers agreed that they were not doing too well in trapping otter although they had seen plenty of otter slides. As one trapper put it, "In order to trap an otter, you have to be smarter than the otter, and maybe they weren't." Whether the season was good or bad, trapping was always a good topic of conversation. Everyone continued to worry about the mail plane and there was much joy when it finally arrived the day before Christmas with dozens of mail sacks for the village.

Early Christmas Eve, families began pouring into the schoolhouse. Each family brought boxes of Christmas gifts to the school since it was the custom in Naknek to bring all of the gifts to the schoolhouse to be distributed. When everyone had deposited the gifts under the Christmas tree, the schoolroom looked like Santa Claus' workshop.

By eight o'clock everyone in the village was crowded into the small schoolroom. One of the taller men climbed onto the table to turn out the house lights and the curtain, made of burlap, parted on the school program. The audience became quiet. Parents shushed a few whimpering babies and struggled to keep wriggling preschoolers in tow. Little Nancy said her poem with the charming inflection which many of the children have who learn to speak Aleut before they speak English. Herman played his piano solo extremely well. The little Christmas play was both entertaining and amusing in spite of difficulties with the curtain and whispered backstage instructions which could be heard in the audience. Since no Christmas gathering is complete without Christmas carols, the roof of the little schoolhouse was almost lifted by the voices of all the people raised in the singing of "O Come All Ye Faithful," "Silent Night," "It Came upon the Midnight Clear," and

finally a rollicking rendition of "Jingle Bells" as Santa Claus came bounding into the schoolroom. Santa had quite a task delivering all of the gifts which had been placed under the Christmas tree, but he managed it well and seemed to have a comment to make on almost every gift.

When all of the Christmas gifts had been distributed the chairs seemed to disappear magically and tables appeared laden with more food than I had ever before seen in one place. White cakes, chocolate cakes, fruit cakes, nut cakes, potato salad, fruit salad, jello salad, sandwiches of every kind, coffee for the grown-ups and milk shakes for the children, and just about everything one could think of in the way of food was in the schoolroom that night. After everyone had eaten and drunk and chatted and wished everyone "Merry Christmas" the families began to move out of the schoolroom and home to put the children to bed so that they would be able to get up early on Christmas morning. Although the gifts were distributed at the schoolhouse Christmas Eve, the children had to wait until Christmas morning to open most of their gifts at their homes.

Christmas day in Naknek was just like Christmas day in any part of the United States. Living rooms were scattered with Christmas wrappings. Children were running about squealing with excitement over the toys they had received. Roast turkey with all the fixings was baking in almost every oven. By the end of the day children and grown-ups alike were well fed and tired but happy, ready for a good night's sleep.

BUT THIS WAS ONLY one of Naknek's two Christmas celebrations since the Aleuts, who follow the Russian Orthodox religion, also celebrate their own Russian Christmas. On the eve of Russian Christmas the natives from Sevonosky village all climbed into their dog sleds and began the round of villages singing Russian Christmas chants. They made their first stop in South Naknek across the river where more singers joined the procession with their dog teams. They came to Naknek in full force, tying their dog teams along the fence around my house (which has been the dog sled "parking lot" for years). They got out their colorful shining stars which they carry as they march around the villages chanting the Russian Christmas hymns. These stars are passed down in the families from generation to generation. Each child and adult treated his star with reverence and felt great pride in its beauty. The singers stopped at every house. Often they were invited in for a hot cup of coffee or tea and cookies or cake. As they left Naknek to go to the next village more dog teams joined them. They continued in this manner, stopping at every house and gathering a larger group as they traveled along until they had visited every home in all of the villages in the immediate area. The long train of dog teams being driven off across the snow-covered tundra made an impressive sight.

New Year's day was bitter cold, thirty below zero with a strong wind blowing. I was glad that it was a holiday so that I would not have to spend too much time out of doors. But as I was sitting toasting my toes at the stove there was a knock on the door. It was one of Naknek's bush pilots.

"We just got a radio message from South Naknek," he said. "I guess that girl who was supposed to go to the hospital to have her baby isn't going to get there. They want you to come over as soon as you can. I think we can make it, but it will take about an hour or two to warm up the plane, so you had better wait here until I send for you."

I checked my maternity kit and started to dress, an involved process when the temperature is thirty below—red flannels, ski pants, warm blouse, sweater, heavy wool socks, fur mukluks, fur parka, and moosehide mits. By the time I was ready I decided that the plane would be warmed up, so I borrowed a sled and hiked to the lake dragging the sled with my maternity kit and nursing bag. My face was so numb with cold when I finally got there that even the drafty two-passenger plane felt warm. The wind was tossing the plane around like a leaf when we took off and I breathed a sigh of relief as the skis cleared the bank and we rose safely above the village. When we approached South Naknek the pilot came in low to look for a

place to land, since he knew this was a rush call and the usual landing place was about two miles from South Naknek. He decided to land the plane in front of the school. The plane bounced, twisted, and bounced again as it settled down on the rough snow. The landing gear was damaged slightly and had to be repaired before the pilot was able to take off for Naknek again.

This was the first time I had raced the stork in a plane and I lost, for the five-pound baby boy had arrived shortly before I did. In the young mother's little one-room house, getting many suggestions in Aleut, which I coundn't understand, from two native midwives, I cared for the mother and her baby. It took a lot of scouting around to find clothing for the baby, for the mother had none. The Aleuts seldom have baby clothes ready before the baby's birth because ancient superstition says that the baby will not be born alive if the mother has his clothes ready beforehand. The mother and baby were soon comfortably bedded down, and I left to find a place to stay for the night. Since the winter sun had set and the wind had risen, the plane was unable to return for me that day.

The following day I visited the mother and the new baby again. Both were doing quite well, but baby John was tightly swathed in the Aleut manner and his feet were wrapped in cloth according to the native custom. He seemed quite happy with this snug wrapping, so rather than go against the custom, I gave him to his grandmother to dress after I had shown her how to bathe him. When the mother and baby were both taken care of I started out to make some other visits in the village, held an immunization clinic at the school, and completed some of the health inspections of the school children, for I knew that I would not be able to cross the river that day since the weather had closed in and no planes had been flying. The next day the sun was shining and the wind had quieted down. As I heard the roar of the plane's motor I packed my equipment in the dog sled and jumped onto the sled runners with the driver, while the dogs strained impatiently at their harness eager to be on their way. With shrill yip-yip-yips the lead dog trotted off at the driver's shouted directions. Swing dogs and wheel dogs fell in behind and the sled glided off over the tundra. The village soon disappeared in the distance and I was on my way once again, leaving behind a new baby starting his life with the New Year.

Maternity Care in Great Britain

(Continued from page 651)

After the delivery of the patient at home, the midwife will attend and nurse the mother and child for at least ten days, teaching the mother at every step how to care for herself, the baby, and the rest of the family, if necessary. As soon as possible after the tenth day, the health visitor visits the mother and gives her any advice she may require. In some cities the midwife and the health visitor meet at the patient's home and discuss the labor, delivery, and infant feeding. In other instances a written report is sent to the Public Health Department or Welfare Center. In rural areas nurses with special training in midwifery, health visiting, and sick bedside care have the responsibility of complete family care. Of course, like all district midwives they are on call for twenty-four hours, giving the service which is so widely appreciated—and so satisfying. Regular relief periods and off-duty times are arranged by the supervisor, and in large areas nurses doing permanent relief duty are employed.

There are still many ways in which our service could be improved and any contribution we, as nurses, can make in maintaining family unity will be of untold value as a stabilizing influence in this constantly changing world.

Let us then give our service and teaching so freely that it can truly be said—

> And what a joy through them to re-survey
> That narrow sweet, now half-forgotten way
> Of selfless service as a way to live—
> Based not on what you win but what you give.
>
> —JOHN MASEFIELD

Practical Nurses – Of Course We Employ Them!

The evolution of the role of practical nurses in a visiting nurse service

ELISABETH C. PHILLIPS, R.N.

THE VISITING NURSE Association of Rochester employed two graduate practical nurses for the first time in April 1948. The following September a third was added to the staff, a fourth in February 1949, and a fifth in May 1949. We believe this gradual expansion was sound. It was done this way not because we did not have qualified applicants but because we wanted to build firmly and be sure that there was a real place for these workers on our nursing teams.

The decision to employ practical nurses was made by the Board of Directors in December 1947 after the question had received considerable attention from several committees. From December until April when we welcomed the first two many details had to be worked out. Qualifications of these workers, salary scales, uniforms, plans for introducing them and supervising their work—all required much time and thought. Policies were set up with the help of representatives of the Staff Association and the supervisory group. It was felt wise to make a careful explanation of the plan to all of the staff, too, as well as to physicians and the lay public.

From the beginning we had the wholehearted support of the Board of Directors, the Medical Advisory Committee, and the supervisory group. They felt that the Visiting Nurse Association was moving with the times and believed that by augmenting the nursing staff in this way the service to patients would be improved. The staff nurses were all interested and willing to accept the idea of the experiment. As was to be expected some of them welcomed it more warmly than others. It was not long, however, before those few who were at first reluctant began to see the worth-whileness of the program. We have never experienced any outright rejection of the practical nurses by the professional group and believe that the careful explanation of the plan to the staff before the first two practical nurses came was helpful in averting this.

In the general publicity releases the board stressed the point that it was in no way apologetic about the new plan and the press emphasized this positive approach. The County Medical Society carried a full column in its monthly *Bulletin* headed "VNA Takes Forward Step," and the plan was outlined in some detail. The following paragraph was included in the general publicity pamphlet written in 1948 and is still used today in explaining our service: "A few graduate practical nurses, licensed in New York State, work with the professional nurses and give care to patients whose nursing needs can be met by persons with their preparation." This kind of publicity has done much to define the role of practical nurses in our employ. We had anticipated difficulty arising out of requests either from physicians or families

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for the practical nurse to assume responsibilities or perform duties incompatible with our program, but this has never arisen.

The employment qualifications set up before the first practical nurses were hired are in effect today. In brief they must be graduates of approved schools of practical nursing, have had at least one year of experience in nursing since that time, and be well recommended for this type of work. The usual personal interview and physical examination required for other employees are given. Appointments of both professional and practical nurses are made by a committee.

In the beginning we resolved not to tie ourselves too closely by rules and regulations concerning the work of practical nurses but to set up general guides, give close supervision, and make periodic evaluations so that the real value of these workers could be determined.

How It Worked Out

Our experience in the employment of graduate practical nurses has been universally satisfactory. We were most fortunate in getting the right type of nurse to begin the program and unusually lucky in being able to draw equally well prepared and suitable persons as we expanded the plan. We have had no turnover in this group to date and have a lengthy waiting list of applicants. We are sure that the patients who have been visited by them have had good care and have been happy to have them. Repeatedly patients have telephoned to ask for the return of a particular practical nurse. Not only have physicians accepted the services of this group for their patients, but a large number of them have now given us blanket permission to use practical nurses in our nursing plan for any of their patients. Physicians whom we meet usually compliment the VNA for having taken the forward step of employing and using practical nurses. The professional nurse staff have accepted them as colleagues and teammates in a broadminded and adult manner. Some of our professional nurses have better working relationships with the practical nurses than others; but this is only natural, just as is the difference in the acceptance of the student by the public health nurses. For the past year there has been a growing and very active participation by the practical nurses in the social and other activities of the staff. In one area office last year the practical nurse served as one of the two representatives on the Staff Council, and this spring another practical nurse was chosen as the new treasurer of the Staff Association.

Two years after the first practical nurses were employed, several committees decided to bring together in writing the policies which have been evolved to govern this part of our work. Represented on these various committees have been the Board of Directors, the Medical Advisory Committee, public health staff nurses, practical nurses, area supervisors, and educational and administrative personnel. There has been much unanimity of opinion expressed by all of these persons. No major changes have been made at this time, but clarification and unification of existing policies have taken place. In examining present practice we found that minor differences had developed in the different area offices. From the experiences in all areas we selected the best policies and brought them together in a formal manner. These policies which have been developed within our own association and have been tested and found good, carry the approval of both the Board of Directors and the Medical Advisory Committee of the VNA.

Governing Policies

The practical nurse is an integral part of the nursing staff although her preparation and responsibilities are not the same as those of the public health nurse. A salary scale had been established based on 80 percent of the beginning salary of professional nurses who are employed without specialized public health nursing study. The maximum salary of a practical nurse does not equal the beginning salary of a professional nurse. An identifying uniform is worn by the practical nurse which avoids confusion with the professional nurse. (This is light grey cut to the same pattern as the public health nurse's. A tape with the words "Licensed Graduate Practical Nurse" is worn over the sleeve seam on the

left shoulder. The coat and hat are black instead of navy.) All the staff wear the same VNA insignia. Practical nurses are eligible for membership in the Staff Association and may hold office if elected.

Introduction of practical nurses

Since the number of practical nurses on the staff will always be limited (at present one is assigned to each of the five area offices) it is likely that newly appointed practical nurses will be introduced individually. The plan for this is made by the educational director and includes appropriate classroom demonstrations and conferences and observations of a public health nurse in the home with particular emphasis on the types of visits the practical nurse will make. However, it is wise for her to see something of the public health nurse's whole work in order that she will understand that she is not prepared to be a substitute for her. Since the agency now has experienced practical nurses on the staff, observations by the new appointee of their work in homes will be included henceforth. During the first two or three months a senior staff nurse will serve as guide and coordinator for the practical nurse and the supervisor will have close contact with her. As time goes on she will learn gradually to work with all the nurses in the area office.

Inservice education

Whenever *suitable* educational experiences are planned for the whole staff in the office or in the community, the practical nurse will be included. Group conferences designed to meet the special needs of the practical nurses are planned by the educational director from time to time. Practical nurses are allowed time to attend meetings of their own state and national organizations in the same way as are the professional nurses. Financial assistance is given for this.

Supervised field visits are made by members of the educational and supervisory departments, and written evaluations are made in the same way as they are for the professional staff. The nurses see these evaluations and have a conference with the observer following such visits.

Generalized policies governing the work of graduate practical nurses

Under the direction and guidance of the area supervisor the public health nurse assumes responsibility for her district and the families living in it who are receiving care from the VNA. Through a team relationship she shares the care of selected patients with the graduate practical nurses on the staff. This selection is made by the public health nurse after consultation with her supervisor. The consent of the physician is secured by her, and it is her responsibility to tell the family and the patient that a practical nurse will be visiting.

The public health nurse is responsible for keeping herself well informed regarding the progress of the patient and the nursing and teaching needs present in the family. She does this by (1) reading the records of visits made by the practical nurse (2) conferring with the practical nurse (3) making visits in the home (4) examining medical orders.

No hard and fast rules are effective regarding the original selection of patients to be assigned to practical nurses or the frequency of the public health nurse's visits to the home after such assignment. The following serve as guides:

1. Patients who have many urgent learning needs will not be visited by the practical nurse. When needs for teaching have been filled the practical nurse may be assigned if the physical and emotional needs are within her scope.[1]

2. The frequency of the public health nurse's visits after assignment of a patient to a practical nurse depends upon:

   a. How well the public health nurse knows the family's needs.

   b. How well she knows the abilities of the practical nurse.

   c. The fact that no patient may have

[1] Federal Security Agency, Office of Education, Vocational Education Division. Practical nursing. An analysis of the practical nurse occupation with suggestions for the organization of training programs. Misc. No. 8, Office of Education, 1947. 144p. U. S. Government Printing Office, Washington 25, D. C. 60 cents.

more than twelve successive visits by a practical nurse without at least one from a public health nurse. (More usually it is not over seven visits.)

d. The fact that no more than four weeks may elapse between the visits of the responsible public health nurse. (It is expected that the period will be somewhat shorter.)

e. The fact that if a practical nurse is supervised in the home by a supervisor, this visit *may* take the place of the public health nurse's visit if the supervisor is satisfied that she has had an opportunity to discover all the nursing needs of the family.

f. The fact that the schedule should be flexible and the practical nurse should be encouraged to suggest that the public health nurse visit whenever she is in doubt.

3. The public health nurse will set up a personal plan for visiting families within her district who are also being visited by a practical nurse.

Specific policies governing the work of practical nurses

1. The usual medical policies governing written orders, renewal of orders, et cetera, apply to practical nurses as well as to the public health nurse.

2. The practical nurse works as a member of the nursing team and in this capacity never assumes responsibility for a district or the entire responsibility for the care given a family or patient.

3. She is not expected to open a case except in an emergency, to determine the frequency of visits or the fee status, to decide when a case is to be closed, or to make the final visit. These duties belong to the public health nurse with whom the practical nurse works and who herself confers with the area supervisor when in doubt. However, the practical nurse is in a position many times to make suggestions to the public health nurse, especially regarding frequency of visits or the advisability of closing the case.

4. Except in an emergency, it is the professional nurse who makes reports to the physician and who asks for subsequent orders.

5. Unless there is a public health nurse from the area office on duty in the field the practical nurse does not work on Saturday, Sunday, or holidays. However, if there is sufficient *appropriate* work for the practical nurse and a public health nurse is available to take new calls and perform the other duties not assigned to the practical nurses, it is expected that the practical nurse will work on these days on a rotating basis. Such arrangements are the responsibility of the area supervisor.

6. The visits of the practical nurse will be interspersed with visits from the public health nurse in charge of the district *at least as often as* once every four weeks or every seven to twelve visits. This means that a patient who is being visited daily by a practical nurse will have a weekly visit from a public health nurse. If the practical nurse is visiting three times a week the public health nurse will visit every two and a half weeks or more often if a need is indicated. If a practical nurse visits once a week the fifth visit is made by the public health nurse.

7. Visits which offer important teaching opportunities are made by the public health nurses. Included in this category are visits made to antepartal and postpartal patients, new babies, and all health supervisory visits. Practical nurses may visit newborn babies if no teaching is required and the reason for the visit lies outside the newborn category as in the following case: The mother of a newborn infant has been taught to give good care and everything is going well in the home. But the mother injures her hand and although she needs no nursing care she is unable to bathe her baby. There is no one else available to do this. In such an instance the practical nurse may be permitted to care for the baby. Similarly, if a pregnant woman becomes ill and needs bedside nursing care rather than instruction or supervision, the supervisor may sanction an *occasional* visit by the practical nurse to give this general care. In such instances specific permission of the supervisor is required.

8. Practical nurses may do colostomy dressings if teaching is not a needed part of the

visit. They do not, however, do colostomy irrigations.

9. Practical nurses may give subcutaneous injections of insulin and intramuscular injections of mercuhydrin. The permission of the supervisor must be secured for a specific practical nurse to give either of the medications to a specific patient. In making her decision the supervisor will consider the history of the patient's physical and emotional reaction to the drug, the type of drug, the dosage, and the abilities of the individual practical nurse. This regulation was established in May 1950 after the Medical Advisory Committee approved the following statement: "Graduate practical nurses may give mercuhydrin by intramuscular injection if the area supervisors are confident, after individual instruction and supervision, that they can do it safely."

10. Hypodermic injections which involve mathematical calculations rather than simple measurement may *not* be given by practical nurses.

11. Practical nurses do not give massage. They may give generalized rubbing for the purpose of stimulation to the circulation. Such generalized rubbing must be part of the nursing care plan discussed with the public health nurse.

12. Individual approval by the area supervisor is necessary for the assignment of surgical dressings to the practical nurse. Only dressings in which cleanliness rather than sterility is essential may be assigned. Usually these fall into two categories: dressings of colostomy openings and chronic ulcers. The supervisor must be sure the practical nurse uses an acceptable technic for the type of dressing needed.

13. All practical nurses record their visits directly on the patients' records. This is done in green ink to enable the responsible public health nurse and area supervisor to find and read the notations quickly and also to be able to count easily the number of visits made by the practical nurse.

14. Practical nurses are expected to hold all information and contents of records confidential except when it is necessary to discuss points with the public health nurse and area supervisor in the interest of the patient's welfare.

Summary

Our experience with practical nurses as part of our nursing teams has been rewarding. We found that practical nurses fit into the staff smoothly when careful preparation for their introduction has been made. With the understanding and cooperation of the physicians in the community we were able to increase the number of practical nurses on the staff. We found it satisfactory not to tie ourselves too closely with rules and regulations about the practical nurse at first. We provided careful and sympathetic supervision and made periodic evaluations of what the service of the new type of worker meant to our organization. At the end of two and a half years we all can say: We are glad to have them as a part of our staff.

Abstracts . . .

DISEASE AND SYMPTOM

The fellow-feeling shown by members of Alcoholics Anonymous indicates how little understanding we have had of the excessive drinker, writes Dr. Leslie A. Osborn, professor and head of the Department of Psychiatry, University of Buffalo School of Medicine, in the May 13 *JAMA*.

Raising the question whether alcoholism is a disease in the literal or metaphoric sense, Dr. Osborn quotes a chronic alcoholic who has gradually lost much of his law practice as saying, "I haven't had a peaceful thought in years." If the hyphenation dis-ease is made, the common indicators of illness will quickly be recognized in the lawyer's case. Moreover, disease also manifests itself in impaired function, readily apparent in the lawyer's professional deterioration.

Medicine has always recognized that alcholism can produce disease. The newer concept is that alcoholism is a disease, to which the accompanying pathological tissue changes are secondary.

While alcoholism is a disease in its toxic effects, it is also a symptom. As to why alcohol is taken to excess, there is not one answer but many. Just as the physician does not group together all patients who cough as "coughers," so in his effort to understand alcoholic patients he should try to know them as persons rather than to classify them.

The lawyer who had not had a peaceful thought in years gives one a glimpse of an inner discomfort hard to bear. Perhaps alcohol in its narcotic effects lessened his immediate distress. Any narcotic first produces analgesia. The need to continue such a temporizing solution is not hard to see. The physician must determine what the inner ill-at-ease may be that can call for such pseudo-relief. He must learn how to offer real relief through therapy rather than leave the patient at the mercy of his anxieties with his inner conflicts undetected and unresolved.

A community center can serve as a coordinating and educational headquarters for an organized approach to all the aspects of this illness. A psychiatrist is needed, particularly one with experience at the community level. He is most effective as part of a "team"—psychiatrist, internist, social worker, psychologist, receptionist, and, for inpatient work, the psychiatric nurse. Added to these in various cases are other workers—clergymen, judges, representatives of social agencies, and the like. Such centers as the one in Rochester, New York, and the University of Buffalo Information and Rehabilitation Center are moves in the right direction.

GUIDANCE IN SCHOOLS

Our public schools have developed a variety of services designed to deal with the emotional problems of pupils, reports Dr. Benjamin M. Spock in *The Child*, August-September 1950.

A few schools have fully staffed psychiatric clinics, others use local psychiatric facilities. Most rapid-growing, however, is the guidance or counseling program. The best of this type are directed by trained guidance workers, whose numbers in our schools increased from 2,000 to 8,000 between 1937 and 1945. However, a recent survey of high schools in the North Central States showed four out of five guidance programs staffed by principals and teachers. While the top programs are concerned with the total adjustment of the pupil, many are limited to such functions as vocational testing.

A worker who has long given effective service towards the adjustment of school youngsters is the public health nurse, often the only link between school and home. Clinical

psychologists and remedial teachers are also playing an effective role.

Another approach is the inclusion of mental hygiene courses in the curriculum. Some of these courses provide sensibly for classroom discussion of everyday problems such as popularity or dating. Others get lost in impersonal discussions without meaning for students. However, the wisdom of emphasizing a single, separate course is questioned by the writer. The relationships of the individual to the world and to himself are the very core of life itself and should be practiced and learned about all day long, all childhood long, if the teacher understands children and her job.

SELF-EVALUATION BY A BOARD OF DIRECTORS

That board members should be more concerned with program activities and less with organizational details was one of the conclusions reached in a self-evaluation project carried out last spring by the Board of Directors of the Greater Hartford Tuberculosis and Public Health Society (Conn.). Hartford and Denver were selected by the National Tuberculosis Association as pilot centers for study as part of the educational survey begun in 1944.

Board members were asked to answer questions prepared by an evaluation committee of their own group. The questions were adapted from a more comprehensive list supplied by the NTA. In brief, they were: (1) How did you become interested in the society and its work? (2) Do the board meetings keep you sufficiently informed about the progress and problems of the society? (3) What suggestions do you have to make meetings more vital?

The replies indicated that the directors became interested in the agency's work through acquaintance with a board member, through being asked to become a corporate or board member, and through volunteer service. A few had had experience with related organizations. There were suggestions that committee chairmen be required to prepare their reports more thoroughly and to present all sides of a question, that there be short talks by staff about specific activities from time to time, and that detailed reports be submitted to members in advance of meetings. The board was enthusiastic about ten-minute, post-meeting discussion periods.

As a result of the study the society has received many thoughtful suggestions, board members have been made to feel their responsibilities more keenly, and some changes have been put into effect.

The project is described in detail in the *Bulletin* of the NTA, June 1950, in a report by P. Corbin Kohn.

CHILDREN AND DIVORCE

Some of the conclusions reached by a study group of parents concerned with the effects of divorce on children, are reported by Sidonie M. Gruenberg, leader of the group, in the spring issue of *Child Study*.

Thirty-two women and five men registered for the three sessions of the group, held under the auspices of the Child Study Association last fall. Of twenty-eight participants who answered a questionnaire, seventeen were divorced, the others either contemplating it or already separated.

Through group discussion, the parents reached substantial agreement on several guiding principles in planning for children in divorce cases. The discussion also brought a measure of release from the worry, fear, and sense of guilt which follows divorce. The parents agreed that:

1. Children should be told the truth about divorce. How much is told, however, should depend on the child's age and ability to understand.

2. Except in extreme instances, the children should continue to know both parents.

3. The parent who lives with the children should make every effort to keep from influencing them against the other parent. Even an irresponsible parent may have a constructive role to play in a child's life.

4. In regard to custody or visiting arrangements, it is important for the child to be rooted in one place. But plans should be reviewed periodically to meet changing needs and circumstances.

(Continued on page 682)

New Books
And Other Publications

TUBERCULOSIS HANDBOOK FOR PUBLIC HEALTH NURSES

Jean South. New York, National Tuberculosis Association, 1950. 88 p. Approximately 50c; write to state and local branches for copy.

This book, though written primarily for public health nurses, will be found most informative and useful to all nurses who care for and have an interest in tuberculous patients and their families.

Nurses who render service to patients and their families in the home, clinic, or hospital will find that this book includes many suggestions for improving nursing service. Supervisors and administrators responsible for procedures and for the quality of service rendered will be stimulated to analyze tuberculosis nursing programs.

The opening chapters discuss the concept of tuberculosis nursing as part of family health service given by generalized public health nurses. Because of the many services which may be needed to help patients and families, nurses must understand community resources and the importance of integrating services of the various agencies.

Other chapters discuss nursing responsibilities for casefinding, chest clinic services, the active tuberculosis caseload. A suggested guide for home visits and education of the tuberculous patient and his family is also included.

The author states that "although record writing takes time from direct service, both are important because they are integral parts of professional services and no visit is complete wthout an adequate record of it." The last chapters are helpful in making clear the purpose and uses of the nursing record and how it plays a part in the appraisal of the nursing service.

The closing chapter discusses epidemiological factors of tuberculosis—its cause, difference between infection and disease, risks associated with primary tuberculosis, death rates, and factors influencing morbidity and mortality.

This book is excellent. It is much needed and should be in every nurse's library as well as in every medical school library. Reading it will result in a better understanding of a total well organized tuberculosis nursing program.

—Ruth C. Farmer, R.N., *Consultant, Tuberculosis Nursing, Department of Health, Detroit.*

COUNSELING THE HANDICAPPED IN THE REHABILITATION PROCESS

Kenneth W. Hamilton. New York, The Ronald Press Company, 1950. 296 p. $3.50.

The author says, "while it does not attempt a blueprint, this book points out the possibility of converting our growing millions of handicapped persons from a national problem to a national asset." In admirable fulfillment of its purpose it not only "points out possibilities" but gives new insight into the rehabilitation process.

The book was written primarily for the use of persons whose professional responsibilities include counseling of the handicapped. It is equally useful as a text for students who are preparing to work with handicapped people, for employers, or for anyone who works or lives with persons who have had injuries or illness with residual handicaps.

A significant contribution of this book is a concisely expressed philosophy of rehabilitation which places the emphasis on the individual and his basic needs as a member of a community. A handicap, ipso facto, does not change human need for some type of successful experience, for self respect, for self support, self determination, and full acceptance of the group. The passive incentiveness attitude sometimes found in the handi-

capped may be an expression of personal defeat and denial because it is the status of a non-participating hanger-on which is frustrating and devastating. It is more difficult to endure than either the discomfort or the inconvenience of the handicap.

With recognition of the human needs of the person who has become handicapped as the starting point in the process of rehabilitation, the goal becomes the realization by that person of a life that is useful, socially and personally satisfying. There is a unifying quality to this philosophy which gives new direction to the program of rehabilitation and suggests a forward step from the "crazyquilt, symptomatic, and even maudlin services" still too frequently observed.

The book presents a comprehensive, exceedingly practical discussion of the counselor's role in the process of rehabilitation, from casefinding to selective placement. The complex needs of the handicapped and the diversity of services required for his rehabilitation have resulted in the employment of a good many specialists. The counselor holds a unifying position because his peculiar function is to help the individual gain an understanding of himself and his problems in order to make use of the resources available to him.

The author takes a realistic view of the need for rehabilitation services which leaves little room for complacency or indifference. The estimated number of handicapped persons in the United States has already reached several millions. According to the U. S. Department of Labor approximately 100,000 are added annually because of industrial accidents. The numbers which will come from current military operations cannot even be estimated. Available trained personnel and facilities are inadequate for the already existing backlog of cases. Without pointing out the obvious, society's two choices in the treatment of the handicapped are clarified. Rehabilitation starts with the diagnosis and develops with treatment so that there is no lapse of time during which the golden opportunity for restoration is irrevocably lost. The handicap is analyzed through a penetrating understanding of the person who has sustained it. Facilities for rehabilitation are considered not from the standpoint of the prerogatives of the various agencies, but from the need of the individual, and joint planning for the benefit of the individual is the important element. Obviously, individualized and coordinated service, in terms of the person's needs, is expensive because it is predicated on competency of personnel and adequate facilities. The product bought is the return of a member of society "to the fullest physical, mental, social, vocational, and economic usefulness" of which he is capable within the minimum period consistent with recovery. The alternative to intensive shortterm treatment is the cost to society of relief of the individual for the remainder of his life, and the despair of the person who knows dependency.

To give an adequate idea of the excellent material in this book would be to summarize the topics, chapter by chapter. On the premise that rehabilitation, like public health, is purchasable and that the community itself sets its own standards and receives whatever quality of outcome its understanding allows, the book is recommended not only for selected professional groups but for general reading.

—Heide L. Henriksen, R.N., *Industrial Nursing Consultant, Minnesota Department of Health.*

THE NUTRITIONAL IMPROVEMENT OF LIFE

Henry C. Sherman. New York: Columbia University Press, 1950. 270 p. $3.75.

In addition to providing the public health nurse with stimulus to follow closely future advances in nutrition, this book will reinforce her conviction that "nutrition is every one's adventure."

Using a style which does not burden the reader with technical language, Dr. Sherman tells the story of the new science of nutrition. He interprets the significance of nutrition research which has been conducted in the last half century and emphasizes its human implications.

Of special interest to the public health nurse will be the material on the relation of the science of nutrition to the nutritional status of individuals and length of life. Also, she will find the chapter on principles and practices a helpful review of reasons behind her daily teaching regarding food selection.

In addition, the book gives the history of the development of this new science, the introduction of the word "nutrition" in the early 1890s, the beginning of federal investigations of human nutrition, the early emphasis placed on energy and protein requirements, the realization of the importance of mineral elements, the growth of the field of vitamin research, and the effects of World War II on the science of nutrition.

An appendix contains a summary of the 1946 World Food Survey of the FAO, records of actual food consumption, and a selected bibliography.

—CATHERINE LEAMY, *Regional Nutrition Consultant, Children's Bureau, Federal Security Agency.*

TEACHING THE RETARDED CHILD AT HOME

Edna Davison Osterhout. Durham, N. C., Duke University Press, 1950. 67 p. $2.50.

All too often public health nurses find children playing at home who are "not quite bright enough" to attend public school but who are *not* rated as feebleminded. Mothers, teachers, and often nurses are at a loss to know how to train and teach these children at home—for they are both teachable and trainable with patience and skill.

Mrs. Osterhout's book—a manual, really—offers parents perfectly simple instructions and materials for teaching these children at home and lists needed equipment. The beginning subjects covered are reading, writing, spelling, numbers, handwork, and games. This is a "health tool" unique in its special field which nurses should keep in mind and recommend to parents in appropriate situations.

—DOROTHY DEMING, R.N., *Public Health Nursing Consultant, Merit System Service, American Public Health Association.*

GROUP MEDICINE AND HEALTH INSURANCE IN ACTION

Robert E. Rothenberg and Karl Pickard; assisted by Joel E. Rothenberg. New York, Crown Publishers, 1950. 278 p. $5.

The Health Insurance Plan of Greater New York (HIP) is the largest nonprofit voluntary organization operating on the basis of group practice and prepayment. Its experience teaches many important lessons on both the potentialities and limitations of the two methods of organization. The authors of this book clearly and vividly describe the mechanics of establishing and operating group practice units in conjunction with a voluntary prepayment plan. Much of their material is derived from the experience of their own group, one of some 30 group practice units affiliated with HIP. Policymakers, planners, and administrators will find valuable information in the chapters on medical personnel, medical standards, administrative and technical personnel, and physical facilities for group practice units, even though the account covers a relatively short period of actual experience under a plan still troubled by growing pains. The nursing profession has good reason for paying attention to any report on the progress of HIP, as this plan is one of the very few in the country which include nursing service. HIP recommends one supervising nurse, ten office nurses, and two home visiting nurses for each group practice unit serving 20,000 persons. The plan buys service from visiting nurse associations in the community on a cost-per-visit basis.

—FRANZ GOLDMANN, M.D., *Associate Professor of Medical Care, Harvard School of Public Health.*

COMMUNITY HEALTH ORGANIZATION

Ira V. Hiscock. New York City, The Commonwealth Fund, 1950. 278 p. 4th edition. $2.75.

The fourth edition of Dr. Hiscock's *Community Health Organization* is considerably improved and expanded when compared with the previous editions. It will continue to be a very useful text and reference book for quite a wide variety of groups: medical and nursing students, public health students, and almost all categories of public health workers.

Community Health Organization is what its name suggests—a description of recommended public health practices and procedures—and as such it contains a great deal of information in a relatively small volume. Of necessity, therefore, many important points are touched on only briefly. There are, however, many excellent references to more detailed source material. These references are conveniently located at the bottom of the pages.

Although there is a thirteen-page chapter

on voluntary health service the remainder of the book refers largely to the official health agency. More space might have been given to the integration of the many official and nonofficial agencies and professional groups, which is so important to good community health organization. This will probably become even more important as more and more communities begin to develop programs along the lines indicated in the chapters, Newer Health Problems and Medical Care Administration.

Dr. Hiscock is quite modern in his thinking, and this is brought out particularly in his chapter on public health nursing. While not all health administrators will agree at this time in regard to the integration of educational and bedside public health nursing, there seems to be a trend along these lines, and such a plan should provide for more efficient community coverage.

The importance of public health nursing to the overall community program is indicated by the recommendation that nearly half of the total budget be allocated to it. While there is no question about the fact that one public health nurse per 2,500 population would be desirable, this does seem somewhat out of proportion to the seven sanitarians per 100,000 population suggested.

—C. Howe Eller, M.D., Dr. P.H., *Director, City Department of Health, Louisville, Kentucky.*

NURSING

Nursing History in Brief. Minnie Goodnow. W. B. Saunders Company, Philadelphia. 3rd edition. 1950. 274 p. $3.00.

Textbook of Anatomy and Physiology. C. C. Francis and G. C. Knowlton. The C. V. Mosby Company, St. Louis. 2nd ed. 1950. 624 p. $6.25.

Textbook of Anatomy and Physiology. Catherine Parker Anthony. St. Louis, C. V. Mosby Company. 3rd edition. 1950. 614 p. $4.00.

Bibliocounseling as a Guidance Technique in Schools of Nursing. Mabel Carroll McCracken. A dissertation submitted to the School of Nursing Education, Catholic University. Washington, D.C., Catholic University of America Press. 1950. 117 p. $2.25. A list of books—critically selected and reviewed, to be used for the guidance of students in schools of nursing—"that will assist them in developing into qualified, professional nurses with a strong Christian personality," covering the spiritual, cultural, social, and vocational fields.

Surgical Nursing. Eldridge L. Eliason, et al. Philadelphia, J. B. Lippincott Company. 9th edition. 1950. 728 p. $4.

Professional Adjustments. Sister Mary Isidore Lennon. St. Louis, The C. V. Mosby Company. 2nd edition. 1950. 362 p. $3.50.

Scientific Principles in Nursing. M. Esther McLain. St. Louis, The C. V. Mosby Company. 1950. 410 p. $3.00.

Administration of Schools of Nursing. Dorothy Rogers Williams. New York, Macmillan Company. 1950. 288 p. $4.00. Especially useful for public health nurses associated with basic schools of nursing.

Quick Reference Book for Nurses. Helen Young, et al. Philadelphia, J. B. Lippincott Company. 6th edition. 1950. 626 p. $3.00.

Physiology and Anatomy. Esther M. Greisheimer. Philadelphia, J. B. Lippincott Company. 6th edition. 1950. 841 p. $4.

Microbiology with Applications to Nursing. Catherine Jones Witton. New York, McGraw-Hill 1950. 692 p. $4.50.

GENERAL

Personal and Community Hygiene Applied. Jesse Feiring Williams and Gloyd Gage Wetherill. W. B. Saunders Company, Philadelphia. 1950. 610 p. $4.00.

Municipal and Rural Sanitation. Victor M. Ehlers and Ernest W. Steel. New York, McGraw-Hill Book Company. 4th edition. 1950. 548 p. $6.50.

Essentials of Medicine. C. P. Emerson and J. E. Taylor. Philadelphia, J. B. Lippincott Company. 16th edition. 815 p. $4.

National Health Insurance Handbook. Committee for the Nation's Health, 1416 F Street, N.W., Washington 4, D.C. 1950. 80 p. 35c. The Handbook summarizes many facets of information on the overall subject of health insurance. It contains facts and reports which everyone interested in the

(Continued on page 682)

FROM NOPHN HEADQUARTERS

NOPHN Executive Committee

The Executive Committee of the NOPHN Board of Directors met for the first time since the Biennial Convention on October 18. Emilie G. Sargent, president of the organization, presided. Our honorary president, Mary S. Gardner, attended. Among the topics of major importance given consideration are recent developments in structural reorganization, and nursing in the national emergency.

Structure

Miss Fillmore reported that the first meeting of the Joint Coordinating Committee on Structure was held in September and NOPHN had been assigned the administrative responsibility for this committee. Previously, the Structure Study Committee was an independent committee; it now is under the guidance of the Joint Board. Pearl McIver, representing ANA, was elected chairman and Louise Knapp of ACSN, secretary.

The big job of the Coordinating Committee on Structure is to complete the design for the new organizations which are to replace the present six and to guide an orderly transfer of program activities. The NOPHN Executive Committee recommended to the Joint Board that a fulltime staff member be employed for this committee during 1951 to make certain that the blueprints for reorganization will be ready by January 1952.

At the meeting of the Coordinating Committee provisions were made for continuing representation of any organization which may be dissolved before the new structure is completed. The committee at present is composed of the chairmen of the structure committees of each of the six organizations, and the presidents and chief executives. Members-at-large will probably be appointed soon.

Ruth Freeman, a member of the Executive Committee and chairman of NOPHN Structure Committee, summarized the work of the Coordinating Committee to date. It has reviewed and revised the general objectives of the proposed new American Nurses' Association and Nursing League of America. These are to be discussed also by the structure committees of the individual organizations and the Joint Board, and reports will be carried in the professional magazines when the objectives have been redefined and further clarified.

The Coordinating Committee will also prepare guides and suggestions for states and districts to help them in reorganizing under the new structure plan. The committee recommends that states with two or more state nursing organizations set up machinery similar to the Joint Board and that one of the first committees to be established under the joint board of state nursing organizations be a joint committee on structure (for the reorganization). Some large districts have local nursing organizations which do not exist in the state pattern. Where this occurs provision should be made for equal representation on the structure committee from organized nursing groups in the districts.

After hearing Miss Freeman's report, the Executive Committee passed the following resolution:

> Inasmuch as there will be need to provide a nucleus of professional and

lay members concerned with public health nursing to help establish the new professional organizations

and

Since such leadership can be developed through use of the existing SOPHNS and their local units,

Be it resolved that every effort be made to strengthen these organizations to promote joint action in state and local situations among existing nursing organizations through machinery similar to that of the Joint Board of the Six National Nursing Organizations.

Nursing in the national emergency

Miss Sargent reported that the Joint Board Steering Committee had requested that it also be made the Joint Committee of Nursing in National Security, as problems in this area are coming to the Steering Committee for consideration. The NOPHN Executive Committee voted its approval of this. The Steering Committee has approved in principle the categorization of nurses by functional activities and also by fields of specialization. (See PHN, November 1950, page 601.)

Social security

The change in status of employees of voluntary agencies under the amended Social Security Act was discussed. The National Health and Welfare Retirement Association cannot make adjustments until the middle of 1951, and the old age and survivors insurance program goes into effect for new participants on January 1, 1951. It is urgent that older workers come under the new insurance provision on January 1 as any postponement handicaps them considerably. (See page 635 and also PHN, October and November 1950, pages 543 and 630.)

The Executive Committee resolved:

> That the NOPHN recommend to its member agencies that they seriously consider seeking coverage for their staffs under the Social Security Act as of January 1, 1951, and if they are participating in the retirement plan of the National Health and Welfare Retirement Association that they arrange to carry both plans for the period 1951 until information regarding possible adjustments is made available by the Retirement Association.

The Executive Committee received reports from several committees and discussed the tentative budget for 1951. In addition to Miss Gardner, Miss Sargent, Miss Freeman, and Miss Fillmore, the following were present: Dorothy Wilson, 1st vice-president, Mrs. H. Stanley Johnson, 2nd vice-president, Mrs. C. Welles Belin, Mrs. Edward H. Bryson, Mary M. Dunlap, Ruth W. Hubbard, Marie L. Johnson, Mrs. Grayson M. P. Murphy, Jr., Mrs. Philip A. Salmon, Margaret S. Taylor, Mrs. Helen T. Watson, and Dr. Ralph C. Williams.

NOPHN MEMBERSHIP CHAIRMEN

Announcement of the appointment of Mrs. Pearl Parvin Coulter, Boulder, Colorado, and Mrs. C. Welles Belin, Waverly, Pennsylvania, as co-chairmen of the NOPHN National Membership Committee has just been made. Mrs. Coulter will head up the 1951 nurse membership campaign while Mrs. Belin will lead general membership promotion activities.

Mrs. Coulter, associate professor of public health nursing, University of Colorado, has played an active role in nursing activities, both state and national, for many years. Her affiliations have included presidency of the Colorado State Nurses' Association and chairmanship of the Collegiate Council on Public Health Nursing Education: a Section of the NOPHN.

Mrs. Belin is a member of the Board of Directors of the Visiting Nurse Association of Scranton and Lackawanna County and has held various offices on the VNA board, including that of president. At the time of her election to the NOPHN Board in 1948 she was also serving as secretary of the Board of Trustees, Waverly Community House, Waverly, Pennsylvania; chairman of the School

Lunch Volunteers of Waverly School; and secretary of the board of Waverly's Committee on Religious Education.

Early renewal of NOPHN membership for 1951 is urged by both Mrs. Coulter and Mrs. Belin. If you do not have a renewal form readily available, you need only write your full name and address on a piece of note paper, mark it "1951 Membership Dues," and send it with a check or money order to NOPHN, 1790 Broadway, New York 19, N. Y. Individual membership dues are $5 per calendar year; $8 includes subscription to PUBLIC HEALTH NURSING. Sustaining membership dues are $10 and include a subscription to the magazine, when requested.

CANCER NURSING

In this issue appears the first of a series of articles on cancer which will be published during the next six or eight months. All the articles have been prepared especially for PUBLIC HEALTH NURSING by three staff members of the National Cancer Institute, U. S. Public Health Service. The authors, Rosalie I. Peterson, Genevieve R. Soller, and Margaret F. Knapp, have worked in collaboration and have made a wide study of source materials to document their papers. The extensive reference lists will be particularly appreciated for inservice educational purposes as well as for general reading.

Plans are under way to reprint the series of articles in booklet form late in 1951.

YOUR EARLY RENEWAL HELPS US—AND YOU!

Checking and recording subscription renewals takes time—even with our present streamlined system. So, to be certain that you won't miss a single copy of PUBLIC HEALTH NURSING, it's a good idea to mail us your renewal at least six weeks before your current subscription expires. Be sure to give your full name and address with a note that payment is for renewal of your subscription.

Early renewals give us time to check our records, to make any needed changes in address, to cut new stencils for the addressograph, to be sure our print order is correct—and maybe even to draw a deep breath between issues!

If you don't know when your subscription expires, just look on the wrapper. You'll find several numbers at the right below your address, indicating month and year of the last issue of your present subscription. For instance, "3-51" means "March 1951."

Be an "early bird"! We'll be ever so grateful.

ABOUT PEOPLE YOU KNOW

Mrs. Louise K. Tooker is retiring as superintendent of the Bureau of Public Health Nursing, Cincinnati Department of Health, and will be succeeded by *Catherine Ludlow*, formerly a supervisor in that organization. . . . *Deborah Bacon* has been appointed dean of women at the University of Michigan. Miss Bacon served with the ANC in World War II. She holds a B.S. degree in public health nursing and a Ph.D. in English. Her nursing background should be valuable in her new activities as university dean.

The Bureau of Indian Affairs announces the retirement of *Sallie Jeffries*, chief consultant in nursing in the bureau. Miss Jeffries has had a varied career in hospitals and in the field of public health nursing. She saw service in France during World War I and is responsible for many of the progressive developments in the nursing program of the Indian Service. Miss Jeffries recently received a meritorious award from the U. S. Department of the Interior.

Mrs. James B. Laib has retired as director of the Bureau of Public Health Nursing, City Health Department, Baltimore. Mrs. Laib joined the department on New Year's Day, 1910. She has seen public health nursing grow from its earliest days through its many stages to reach today's developments and she has played an active part throughout these years. Mrs. Laib has been closely associated with the Maryland SOPHN. . . . *Alice M. Sundberg*, since October 1946 assistant direc-

tor, now assumes the position of director, Bureau of Public Health Nursing, Baltimore City Health Department. . . . During the past summer *Mary V. Adams* resigned as director of public health nursing, School of Nursing, Duquesne University. Miss Adams plans to travel for an extended period.

Mary Lee Taylor has accepted the position of associate dean in the School of Nursing, Emory University. Miss Taylor has been a public health nurse in Bowie County, Texas. . . . The VA announces the appointment of the following chief nurses: *Mrs. Mary G. Leach* to Salt Lake City; *Genevieve Romeo* to Milwaukee; *Mrs. Nova L. Young* to Portland, Oregon. . . . *Frances M. Hersey*, who has been director of public health nursing, Wyoming State Department of Public Health, has accepted the position of supervisor of the new Wyoming Home and Hospital for the Aged. . . . *Franziska Glienke*, director of the VNA of Syracuse for the past three years, is now public health nursing consultant with the Pan American Sanitary Bureau. Her first assignment is in Costa Rica where she will work with *Mary X. Rogan*, formerly of Syracuse University, in integrating the social and health aspects of nursing in the basic course at the School of Nursing, San Juan de Dios Hospital.

The University of Michigan announces the appointment of *Alice V. Hagelshaw* as assistant professor of public health nursing in the School of Public Health. Miss Hagelshaw has had extensive experience in public health nursing. She previously was an instructor at Simmons College. . . *Jean Stair*, recently supervisor with the VNSNY, is now assistant professor in public health nursing at the College of Nursing, Wayne University.

The Children's Bureau has announced the resignation of *Dr. Leona Baumgartner*, who has been associate chief of the bureau since June 1949. Dr. Baumgartner returned to her former position as assistant commissioner of health, New York City Health Department, but will continue to serve as a special adviser to the Children's Bureau. . . . *Ruth R. Puffer*, director of Statistical Service, Tennessee Department of Public Health, and a member of the NOPHN Board of Directors, is serving as consultant for the United Nations and is teaching at the Inter-American Seminar on Biostatistics in Chile. . . . *Dr. William H. Sebrell* has been appointed director of the National Institutes of Health, Public Health Service. He succeeds *Dr. R. E. Dyer* whose resignation was announced last month. Dr. Sebrell is a leading authority on nutrition and has had varied experience in other fields of medical research.

NOPHN FIELD SCHEDULE—NOVEMBER

APHA Convention	St. Louis, Mo.
M. Olwen Davies, Ruth Fisher, Jean South, Louise M. Suchomel, Marie Swanson, Marjorie L. Adams, Helen V. Connors, and Judith E. Wallin	
Other Field Trips	
Anna Fillmore	Baltimore, Md.
	Augusta, Ga.
Hedwig Cohen	Albany, N. Y.
M. Olwen Davies	Columbus, Ohio
Ruth Fisher	St. Louis, Mo.
Marion Kerr	Philadelphia, Pa.
Anne Prochazka	Abingdon, Va.
Dorothy Rusby	Holyoke, Mass.
	S. Portland, Me.
	Portland, Me.
Jane Sloan	Peoria, Ill.
Jean South	Cleveland, Ohio
	Cincinnati, Ohio
	Baltimore, Md.
Marjorie L. Adams	Hartford, Conn.
	Torrington, Conn
	Troy, N. Y.
Judith E. Wallin	Joplin, Mo.
	Kansas City, Mo.
	Iowa City, Iowa
	Marshalltown, Iowa
	Winnetka, Ill.
	Willmette, Ill.
	La Grange, Ill.
	Oak Park, Ill.
	Elgin, Ill.
	Gary, Ind.

October field trip not previously reported: Marion Kerr, Paterson, New Jersey.

NEWS AND VIEWS

HIGHER EDUCATION IN THE NATIONAL SERVICE

At the Conference on Higher Education in the National Service called by the American Council on Education in October (see PHN, November 1950, page 622) the following declaration, first made at the 1942 conference while the country was at war, was reaffirmed:

> We pledge to the President of the United States, Commander-in-Chief of our nation, the total strength of our colleges and universities—our faculties, our students, our administrative organizations, and our physical facilities.

The conference adopted the further statement that:

> The greatest power of the nation lies in well educated and well trained men and women. To increase this power, it is imperative that opportunities for higher education for secondary school graduates of superior ability be substantially increased, irrespective of race, creed, or economic status.

In addition to general meetings there were ten work sections. Of special interest were the sections on manpower utilization and civil defense. The group had a clear realization that the future presents a different framework from that in which manpower problems have been viewed in the past. There seems to be a struggle between two opposing concepts of human organization which may be continued for many years. Although there is the possibility of wide-scale combat the struggle may be only partly and sporadically military; it is certain the struggle will also take other forms. There will be a real test of our ability to maintain our economic, political, and social structures. The responsibility of our nation to vast areas of the world and the role it adopts are highly significant in the outcome of the struggle. There will be an increased demand for manpower with advanced training and competence in a wide variety of fields not only those of importance to military and technological efforts. The section considering manpower passed these resolutions:

> That a student deferment policy is to the national interest.
>
> That methods of selecting students for deferment should employ measures of individual aptitude and also take cognizance of the continuing educational performance of the individual.
>
> That deferments should be granted on the basis of individual ability and accomplishments and not on the basis of courses or curricula leading to specific professions or vocations.

The American Council on Education will continue study of college student deferment and will emphasize the obligations of students to serve in the national interest after training.

The section which discussed civil defense stated, "Distasteful as it may be it seems inevitable that civil defense activities properly conceived and executed must be made an integral and continuing part of the pattern of our living."

A complete report of the conference will be available at a later date.

IMPROVEMENT OF NURSING SERVICES

Having been given a grant of $200,000 by the W. K. Kellogg Foundation, the National Committee for the Improvement of Nursing Services will launch a dynamic program to improve nursing services in hospitals and health agencies in the next three years. The NCINS, sponsored by the six national nursing organizations and composed of representatives of nursing, medical, hospital, and general edu-

cation fields, will be broadened to include members from dentistry, social science, industry, labor, public health, governmental agencies, and consumers of nursing service. The Joint Commission for the Improvement of the Care of the Patient will serve as an interprofessional advisory committee.

Committees for the Improvement of Nursing Services are being set up in the states and territories also. Their major responsibilities will be carrying out the objectives of the national program as they relate to state activities. Among these are: planning by regions and states for the elimination of substandard schools; improvement of schools of nursing, degree and diploma, which hold possibilities of becoming sound educational institutions; development of strong inservice educational programs for nurses concerned with nursing administration; development of a variety of graduate programs to provide preparation beyond basic nursing education; promotion of practical nurse education on a sound basis to increase the number of trained practical nurses.

Mary Ellen Manley of the New York City Department of Hospitals is chairman of the committee, and Marion W. Sheahan and Helen C. Goodale continue as NCINS director of programs and secretary, respectively.

VNSNY MOVES

Friends of the Visiting Nurse Service of New York, scattered all over the world, will be interested in learning that the agency moved on November 1 from "262" to temporary headquarters at 598 Madison Avenue. The move was necessitated by the sale of the property for a skyscraper office building.

Many will remember this charming building, given when the service was called the Henry Street Visiting Nurse Service of New York "In memory of Jacob Henry Schiff by Therese, his wife, and dedicated to the cause of Public Health Nursing which he long fostered for love of progressive education, civic righteousness and merciful ministration." Since 1940 this building has been not only the administrative headquarters for the Visiting Nurse Service of New York but also a meeting place for many other nursing and allied civic groups.

Miss Marian G. Randall, executive director of the service, voiced the feeling of all of the staff and volunteers when she said, "Needless to say, we all regret the loss of the attractive building at '262,' but considering all the factors involved —the financial offer was good, the

Arnold Eagle

"Through this doorway have passed some of the most famous nurses in the world."

character of the area is changing with traffic very heavy, a tall building built around us would not be very comfortable and would lower the value of our property—a sale and move seemed necessary. All of the historic and remembered articles of furniture, pictures and fixtures that can be removed will be used in the temporary headquarters or preserved for the day when another permanent headquarters building is secured. Arnold Eagle has made a photographic record of the building for the historic file and to assist our memories when we plan again. When we are settled in our temporary headquarters we shall look forward to seeing you there and you can be sure the same welcome awaits you as at '262.' When the new permanent headquarters is ready, there will be open house for all our friends."

CIVIL DEFENSE COURSES

A series of instruction courses for professional nurses in preparation for possible atomic attack has been arranged by the National Security Resources Board as part of the civil defense training program. The courses, in which the Public Health Service and the Atomic Energy Commission are participating, are designed to provide a nucleus of trained teachers in the field of atomic medicine for the instruction of professional nurses.

Instruction will be devoted mainly to health problems arising from atomic attack and the nursing technics involved. It is planned that those who complete the courses will be available in state training programs to train other nurses as teachers.

The state governors have been invited to nominate nurses to receive this training. It is suggested that committees made up of representatives of the state nurses' association, state department of health, and the university schools of nursing in the state help select the candidates. Qualifications will be reviewed by the USPHS and the Atomic Energy Commission.

The courses will be given in Rochester, Atlanta, New Orleans, Minneapolis, Denver, and San Francisco.

The subject of civilian defense was highlighted at the annual conference of the Association of State and Territorial Health Officers in October. Among the problems considered are: methods of handling mass evacuations and of preventing panic reactions; allocation of critical materials needed for treatment of casualties; plans for blood-typing the population; methods of instructing public health personnel and private physicians in new treatments which may be necessary. The association has set up a civil defense committee under the chairmanship of Dr. Vlado A. Getting.

SCHOLARSHIPS

Wayne University College of Nursing has available a limited number of scholarships for graduate nurses who wish to prepare for positions in maternity nursing or child care nursing. Funds for these have been provided by the U. S. Children's Bureau.

The scholarships cover fees and a monthly stipend for a two-semester period. In some cases, the scholarship may be used over a four-semester period.

Interested nurses should secure application forms as soon as possible from: the dean of the university's College of Nursing, 5257 Cass Avenue, Detroit 2. Information about previous education and experience should accompany the request for an application form.

ARC STAFF CHANGES

The American National Red Cross announces the resignation of Ruth Freeman as administrator, Nursing Services. She is succeeded by Ann Magnussen who has been deputy administrator, Nursing Services, since 1948.

Miss Freeman has accepted the position of associate professor and head of the Division of Public Health Nursing, School of Hygiene and Public Health, Johns Hopkins University. She is the author of the recently published *Public Health Nursing Practice* and of the earlier *Techniques of Supervision in Public Health Nursing*. Miss Freeman has been closely associated with NOPHN activities. She is a past vice-president of the organization and at present is a member of the Board of Directors and Executive Committee.

While on the staff of the ARC, Miss Free-

man was nursing consultant to the Health Resources Office of the National Security Resources Board. She will continue in this position.

Miss Magnussen is well known to nurses throughout the country, having served with the Red Cross in both the midwestern and southeastern areas before going to the national headquarters.

INTEGRATION OF PUBLIC AND PRIVATE AGENCIES

The integration of voluntary public health nursing agencies into the plans now under way in New Jersey for reorganized public health districts, was urged by Mrs. Howard Runyon, speaking for the New Jersey SOPHN at a June public hearing of the Governor's Committee on Local Health Administration.

The committee, which will draft proposed legislation for larger, more effective, local health units, conducted the hearing to discuss alternative proposals to this end. New Jersey is one of six states without such permissive legislation.

Endorsing the ends of the committee, Mrs. Runyon, member of the NOPHN Eligibility Committee and of the Board and Committee Members Section, said:

> All over the country, there are experiments in the integration of official and voluntary agencies. Whether any of these organizational charts should be tailored to fit the New Jersey picture or whether new systems of integration will be developed for our state will, we are sure, be very carefully weighed and decided by the committee.
>
> In New Jersey there are 28 voluntary public health nursing agencies that are members of the National Organization for Public Health Nursing. They are turning at both professional and board member levels for guidance to that important organization. Not to use these individuals and organizations would be to squander resources valuable at local or higher levels. Citizen participation is the essence of earnest and intelligent support.

Mrs. Philip A. Salmon, chairman of NOPHN's Board and Committee Members Section and member of the New Jersey SOPHN's Lay Section, reinforced the proposals made by Mrs. Runyon and promised the support of her organization for suitable legislation for effective health units in New Jersey.

A full report on the hearing is carried in the September 1950 *Public Health News* published by the New Jersey State Department of Health.

GRAPHIC ILLUSTRATION

A new edition of Teaching Aids for Professional People is announced by the Nutrition Association of Greater Cleveland. The aids, a set of twenty cards showing, by color bars, the comparative food value of common foods, provide excellent illustrative material for nutritional teaching in interviews.

This edition includes five new cards particularly useful in teaching nutrition to expectant mothers. The cards are 3½ by 6½ inches in size. Single sets are 50 cents, quantities of fifteen or more, 40 cents a set. The association's address is 1001 Huron Road, Cleveland 15.

AJN AWARD TO ELEANOR ROOSEVELT

At the golden anniversary dinner of *The American Journal of Nursing* the magazine's first citation for distinction in humanitarian service was awarded to Mrs. Eleanor Roosevelt. In presenting the award, Assistant Surgeon General Lucile Petry said Mrs. Roosevelt had been selected

> For her warm response to people in need of help; for her achievements in assisting many peoples to improve their conditions of life; for her deep concern in the welfare of the young;
>
> For her spirited championship of democratic concepts and her unwavering attitude that fears and sicknesses of society must be wiped away, allowing men and women everywhere to enjoy the fruits of freedom, health, and individual labor;
>
> For her courageous and persistent leadership among the peoples of the world to bring about the international adoption of a Declaration and a Covenant of Human Rights through which human dignity might flourish and its richest potentials be realized;
>
> For her accomplishments in public affairs; for her womanliness which evokes universal affection; and for her personal excellence which lifts the status of women.

(Continued from page 673)

subject should be aware of, regardless of his stand on an admittedly controversial topic.

THE COORDINATION OF EDUCATION AND NURSING IN GENERALIZED PROGRAMS. Edited by Kathryn W. Cafferty. Washington, D.C., The Catholic University of America Press. 1950. 174 p. $2.75.

THE LABORATORY GUIDE IN CHEMISTRY. Joseph H. Roe. C. V. Mosby Company, St. Louis, Mo. 2nd edition. 1950. 216 p. $2.25.

A LAMP IS HEAVY. Sheila MacKay Russell. J. B. Lippincott Company, Philadelphia. 1950. 257 p. $3.

Fictionalized account of the progress of a student nurse, written with insight and humor. How young we were then, and what tremendous crises we survived!

SEX EDUCATION

SEX WITHOUT FEAR. S. A. Lewin and John Gilmore. Lear Publishers, New York City. 1950. 121 p. $3.

PSYCHIATRY

PSYCHIATRY FOR SOCIAL WORKERS. Lawson G. Lowrey. New York, Columbia University Press. 2nd edition. 1950. 385 p. $4.50.

EDUCATION

POINT FOUR AND EDUCATION. Pamphlet prepared by the Educational Policies Commission of the National Education Association of the United States and the American Association of School Administrators. National Education Association, 1201 Sixteenth Street, NW., Washington, D.C. 1950. 27 p. 20c; discount on quantity orders.

GOALS OF AMERICAN EDUCATION, a report of the 14th educational conference, New York City, 1949, held under the auspices of the Educational Records Bureau and the American Council on Education. Edited by Arthur E. Traxler. Washington, American Council on Education. 1950. 148 p. $1.50.

NUTRITION

NUTRITION AND DIET THERAPY. F. T. Proudfit and C. H. Robinson. New York, Macmillan Company. 10th edition. 1950. 950 p. $4.00.

NUTRITION IN HEALTH AND DISEASE. Lenna F. Cooper, et al. Philadelphia, J. B. Lippincott Company. 11th edition. 1950. 743 p. $4.

MATERNITY CARE

THE RHESUS DANGER. R. N. C. McCurdy. London, William Heinemann. 1950. 138 p. 5 shillings. A discussion of the medical, moral, and legal aspects of the Rh factor.

Children and Divorce

(Continued from page 669)

5. However special the problems of divorce may seem, problems of child rearing come up in every home. Children may be better off in a divorced home than in one torn by dissension.

6. By one means or another, parents should convey to children the idea that "we have failed in our marriage, but this does not mean that you won't do better."

PUBLIC HEALTH NURSING

DECEMBER
1950

TIME FOR *Thantis* LOZENGES

For throat irritations 'Thantis'* Lozenges provide effective relief. 'Thantis' Lozenges are especially beneficial in soothing these conditions because they are both antiseptic and anesthetic for mucous membranes of the throat and mouth. These effects are due to the two active medicinal agents, 'Merodicein'* an antiseptic of low toxicity, and Saligenin, a mild local anesthetic. When 'Thantis' Lozenges are dissolved in the mouth, the two ingredients dissolve slowly, providing prolonged medication of the throat.

Each lozenge contains 'Merodicein' (H. W. & D. brand of monohydroxymercuridiiodoresorcinsulfonphthalein-sodium) 1/8 grain, Saligenin (orthohydroxybenzyl-alcohol, H. W. & D.) 1 grain.

Supplied in vials of 12 lozenges in individual cartons packed in dozens.

*Reg. U. S. Pat. Off.

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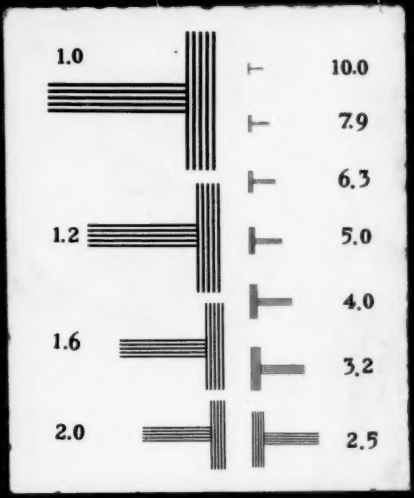
RESOLUTION CHART



100 MILLIMETERS

INSTRUCTIONS Resolution is expressed in terms of the lines per millimeter recorded by a particular film under specified conditions. Numerals in chart indicate the number of lines per millimeter in adjacent "T-shaped" groupings.

In microfilming, it is necessary to determine the reduction ratio and multiply the number of lines in the chart by this value to find the number of lines recorded by the film. As an aid in determining the reduction ratio, the line above is 100 millimeters in length. Measuring this line in the film image and dividing the length into 100 gives the reduction ratio. Example: the line is 20 mm. long in the film image, and $100/20 = 5$.

Examine "T-shaped" line groupings in the film with microscope, and note the number adjacent to finest lines recorded sharply and distinctly. Multiply this number by the reduction factor to obtain resolving power in lines per millimeter. Example: 7.9 group of lines is clearly recorded while lines in the 10.0 group are not distinctly separated. Reduction ratio is 5, and $7.9 \times 5 = 39.5$ lines per millimeter recorded satisfactorily. $10.0 \times 5 = 50$ lines per millimeter which are not recorded satisfactorily. Under the particular conditions, maximum resolution is between 39.5 and 50 lines per millimeter.

Resolution, as measured on the film, is a test of the entire photographic system, including lens, exposure, processing, and other factors. These rarely utilize maximum resolution of the film. Vibrations during exposure, lack of critical focus, and exposures yielding very dense negatives are to be avoided.